# Bodily Integrity

# *For Both*

## The Obligation of Amnesty International to Recognize All Forms of Genital Mutilation of Males as Human Rights Violations

Submitted to the International Executive Committee
by
Amnesty International Bermuda

Aboriginie Circumcision Initiation

"Rape and other forms of sexual assault harm not only the body of the victim. The more significant harm is the feeling of total loss of control over the most intimate and personal decisions and bodily functions. This loss of control infringes on the victim's human dignity . . ."*

*Final report of the United Nations Commission of Experts established pursuant to security council resolution 780 (1992), S/1994/674/Add.2(Vol. V), Annex IX: "Rape and sexual assault", Part I., Section D: "Conclusions." URL: http://www.uwe.ac.uk/facults/ess/comexpert/ANX/IX.htm#1.D

"States Parties shall take all appropriate measures:

"(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes . . ."

*Article 5*
*Convention on the Elimination of All Forms of Discrimination Against Women*

# Bodily Integrity For Both:

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Amnesty International Bermuda

prepared by
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# CONTENTS

# INTRODUCTION: The Context From Which This Report Arises

"Now just as certain gods are believed to be bisexual, so every person is believed to be endowed with the masculine and feminine "souls". These "souls" reveal their respective physiological characteristics in and through the procreative organs. Thus the feminine "soul" of the man, so it is maintained, is located in the prepuce, whereas the masculine "soul" of the woman is situated in the clitoris. This means that as the young boy grows up and finally is admitted into the masculine society he has to shed his feminine properties. This is accomplished by the removal of the prepuce, the feminine portion of his original sexual state. The same is true with a young girl, who upon entering the feminine society is delivered from her masculine properties by having her clitoris or her clitoris and labia excised. Only thus circumcised can the girl claim to be fully a woman and thus capable of the sexual life."

—Shaalan, M. (1982). Clitoris Envy: A Psychodynamic Construct Instrumental in Female Circumcision. *WHO/EMRO Technical Publication: Seminar on Traditional Practices Affecting the Health of Women and Children in Africa*, pg.271. Alexandria.[1]

"When human beings first arrive in the world, they are both male and female and possess twin souls. The boy's "female soul" is in the prepuce, the female element of the genitals, and the girl's "male soul" is in the clitoris, the male element . From the moment of birth, the Bambara child is inhabited by the *Wanzo*, an evil power which is in his blood and skin, and a force of disorder within the individual. The *Wanzo* prevent fecundity. The prepuce and the clitoris, seats of the *Wanzo*, must be severed to destroy the malefic power."[2]

—Epelboin, S and Epelboin, A. (1979) Special Report: Female Circumcision. *People*, 6(1), 24-29.

At the 23rd International Council Meeting of Amnesty International—held at the University of Western Cape, South Africa 12-19 December 1997—the Bermuda Section presented Resolution A3.6: *Gender Distinction in Genital Mutilation.* (The original name of the resolution on its submission was: *Resolution to Remove Sex Distinction From the Abuse of Genital Mutilation.*)

This resolution was presented in Working Party A at approximately 10:15pm on the night of 14 December. On the instruction of the Working Party Chair, the resolution was presented out of the order set down in the Working Party A agenda. This placed it *before* resolutions A3.1 & A3.2—*Abuses by Non-State Actors & Amnesty International and Governmental Inaction*—and resolutions A3.3/3.4/3.5—*Female Genital Mutilation (FGM)*—on which consideration of its relevance hinged.

LeYoni Junos of the Bermuda Section proposed the resolution as requested, noting that international human rights standards on which Amnesty based its very existence—in addition to its Statute—prohibit the distinction of sex/gender in the defense of human rights violations, and that those persons of the male gender were entitled to the same recognition of the right to genital integrity as afforded to those persons of the female gender. Ms. Junos stressed that both the *Universal Declaration of Human Rights* and the *Convention on the Rights of the Child* guaranteed this principle unquestioningly, and invited Amnesty International to reaffirm its commitment to this principle.

The Chair of Working Party A—Johanna K. Eyjolfsdottir of the Icelandic Section—announced the taking of two speakers for, and two speakers against, the resolution. No one requested to speak for the resolution and two speakers spoke against the resolution. The first speaker was Orna Rabinovitch-Pundak of the Israel Section, who argued that the resolution was a low priority and remarked that she came from a country where all male infants were automatically circumcised. The second speaker was David Matas of the French-Canadian Section who voiced his opinion that the adoption of such a resolution would bring ridicule to Amnesty International and ended by calling the resolution itself "ridiculous!" Neither of these speakers referred to or refuted the principle of non-discrimination enshrined in the UN documents cited by the Bermuda Section as its pivoting argument.

In response to the strong remarks made by the French-Canadian delegate, Henry E. Jones of the Colombian Section requested to speak. He rebuked the remarks made by the French-Canadian delegate as out of order, and called upon the Chair to request a formal apology to the meeting from the delegate, and for his comments to be stricken from the record. The meeting showed its immediate approval of this proposal and the delegate in question apologised to the meeting, and his comments were deleted from the record.

Following the Bermuda Section's right of reply, the resolution was put to vote and was defeated by a large majority, with several (approximately 12) abstentions. Later on in Working Party A, resolution A3.1—*Abuses by Non-State Actors*—and the combined resolutions on *FGM* (A3.3/A3.4/A3.5)—Bermuda also being one of the proposers of these—were carried by a comfortable majority.

In the plenary, in the order of the Working Party A Report, the resolution on *Abuses by Non-State Actors* and the resolution on *FGM* were presented and carried. Then the rapporteur read the minutes of the Working Party A Report concerning the defeat of the Bermuda Resolution A3.6. The rapporteur read: ". . . several sections put forward arguments against the resolution . . .", while the actual text read: "There were arguments against the resolution and it was then put to vote. The resolution was defeated by a large majority."[3] At this point, the Bermuda Section raised a point of order. The Section felt that the minutes were not only untrue, but misleading. They contested that there were no arguments against the resolution and that—since of the two speakers against the resolution, one speaker's comments were seen to be abusive enough to be stricken from the record— "several sections" putting "forward arguments" was an unacceptable and misleading record of the proceedings. When asked by the Chair of the plenary—Paul Hoffman—as to whether the Section would be happy with "the resolution was discussed" this was rejected on the same principle. The Section was adamant that the principle of the resolution—distinction according to sex—was never discussed or debated.

Next, and most significantly, the Bermuda Section asked permission of the Chair to seek clarity from the International Executive Committee (IEC) on the current status of the Bermuda resolution, in light of the fact that the resolutions on *Abuses by Non-State Actors* and *FGM* had carried. Specifically, the Section wanted to know if—in the light of these two resolutions being adopted by the International Council, and in the broader light of the application of the principle of non-discrimination by sex—it could do promotional work on the issue of male genital mutilation. Permission by the Chair was reluctantly granted and the IEC responded to the question with a statement to the effect "that the question would have to be put as to whether or not male genital mutilation is a human rights violation." The Bermuda Section responded that since the genital mutilation of females had been established by the International Council as a human rights violation and that since the principle of no sex distinction applies unquestioningly in the defense of all human rights violations, then the answer to the question seemed self-evident. This exchange between the IEC and the Bermuda Section culminated with the IEC extending an invitation to the Bermuda Section to submit to the Committee a formal report "proving" that male genital mutilation is a human rights violation. The inference was that if it could be "proven" that this was the case, then the Section would be within its rights to do promotional work on this issue. The Section accepted the invitation and herewith is the report promised.

*The report is by no means a treatise on the subject of male genital mutilations. Classification of types of mutilations, full geographical distribution, varying cultural practices, historical occurrences, full psychological consequences, etc., are not tackled here. The purpose of the report is to illustrate the human rights perspective of the practice. The Bermuda Section trusts that the International Executive Committee will study this report with a view to enabling Amnesty International to embrace the right to physical and mental integrity of the female as well as the male, in a world where the separation of the rights of the sexes has been sanctioned for too long; and where the recognition of the indivisibility and interrelatedness of the rights of either of the sexes—without the exclusion of the other— will engender tremendous steps towards the achievement of a better world for both.*

# PART 1
# FEMALE GENITAL MUTILATION AND ITS STATUS AS A HUMAN RIGHTS VIOLATION

## DEFINITION OF FEMALE GENITAL MUTILATION

In 1995 the World Health Organization (WHO) published the following definition of Female Genital Mutilation:

> "Female Genital Mutilation comprises all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reason." [4]

Two years later, in 1997, WHO published an updated definition:

> "Female Genital Mutilation (FGM), sometimes referred to as female circumcision, comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons."[5]

The main changes in the latter definition were (1) a recognition of the term "circumcision" as applied to Female Genital Mutilation; and (2) a recognition of the mutilation if it is done for "religious" reasons, as well as cultural and non-therapeutic reasons.

In its 1995 reference, WHO goes on to "classify" the different types of female genital mutilation that may "fall under the definition given above." For the purposes of this report we will cite the first three types:

Type I: Excision of the prepuce *with or without* excision of part or all of the clitoris

Type II: Excision of the clitoris together with *partial or total* excision of the labia minora

Type III: Excision of *part or all* of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

**It can be concluded from the above that any removal "partial or total" of female genitalia— starting with the removal of the female prepuce— is a genital mutilation.**

## DEFINITION WITHOUT THE SEX DISTINCTION

If international human rights standards of equality and non-gender specificity are applied to the cited WHO definitions of Female Genital Mutilation, a concise definition of Genital Mutilation becomes apparent. Without the gender-distinctive adjective, "female", the 1997 WHO definition reads as follows:

> "Genital Mutilation, sometimes referred to as circumcision, comprises all procedures involving partial or total removal of the external genitalia or other injury to the genital organs whether for cultural, religious or other non-therapeutic reasons."

Type I of the WHO classification of FGM specifies "excision of the prepuce *with or without* the clitoris" as a "type" of genital mutilation.

A further application of international human rights standards of equality and non-gender distinction to this classification would render "excision of the prepuce" *of either gender*, a "type" of genital mutilation.

It is clear from the above definitions and classification that any removal "partial or total" of the female genitalia—starting with excision of the prepuce—is seen as a mutilation of normal female genitalia.

**Apply international human rights standards by removing the gender distinction and it becomes clear that—regardless of the sex of the individual—any removal "partial or total" of normal genitalia—starting with the removal of the prepuce—is a genital mutilation.**

## AMNESTY INTERNATIONAL'S RECOGNITION OF FGM AS A HUMAN RIGHTS VIOLATION

Amnesty International (AI) adopted Female Genital Mutilation as a human rights violation in 1995. While the focus was on the genital mutilations of females only, Decision 6 of the 22nd International Council Meeting (ICM) contained the following *gender-neutral clauses,* which highlighted the human rights issue of individual bodily integrity regardless of any distinction:[6]

> "***considering*** that Article 1 of the Statute, as amended by the 1991 ICM, provides that AI's mandate includes the promotion of awareness and adherence to the *Universal Declaration of Human Rights* and other internationally recognized human rights instruments and the values enshrined in them, as well as the indivisibility and interdependence of all human rights and freedoms;
>
> "***considering further*** that AI's mandate includes opposing grave violations of the rights of all persons to be free from discrimination on the grounds of their ethnic origin and sex and of the right of all persons to physical and mental integrity;
>
> "***noting*** that international human rights law underscores the obligations of UN member-states to respect and to ensure the protection and promotion of human rights, including the right to non-discrimination, the right to physical and mental security, and the right to health;
>
> "***recognizing*** that the UN *Convention on the Rights of the Child* states in article 24 (3) that 'States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children' and in article 19 that 'States take measures to protect the child from all forms of physical violence [and] injury . . .'"

In *gender-specific terms,* Decision 6 states explicitly "that the practice of female genital mutilation (FGM) violates those human rights as it continues to be gravely and extensively committed on the bodies, and to affect the lives, of millions of girl-children and women."

**It can be concluded, therefore, that Amnesty International currently recognizes the mutilation of female genitalia *only* as a human rights violation. This is in conflict with the provisions of its Statute to uphold the "right of *all persons* to physical and mental integrity."**

# PART 2
# REASONS GIVEN FOR NOT RECOGNIZING GENITAL MUTILATION OF MALES AS A HUMAN RIGHTS VIOLATION

## (A) Reasons of Anatomical Differences and Importance of Male Ritual

In *Cutting the Rose: Female Genital Mutilation—The Practice and Its Prevention,* author Efua Dorkenoo[7] briefly addresses the issue of male genital mutilation. On page 52 she writes:

> "Many men point out that males undergo circumcision and similar rites of passage too and, as such, FGM is not a mechanism used by men to oppress women. There are similarities and dissimilarites between FGM and male circumcision and also between the rites of passage for boys and girls. Certainly the two procedures are related. *Both are widely practised without medical necessity and in both cases children go through a traumatic experience. Both are performed on children without their consent.*" [our emphasis]

Initially the writer gives three points of information that immediately bring the circumcision of females *and* males squarely into the sphere of human rights violations. She acknowledges:

1) that **"both are widely practised without medical necessity";**

2) that **"in both cases children go through a traumatic experience";**

3) and that **"both are performed on children without their consent."**

"But" . . . as she goes on the say:

> ". . . there the parallel ends. The clitoris is biologically equivalent to the penis. Clitoridectomy, which is the most common form of FGM, is analogous to penisectomy rather than to circumcision. Male circumcision involves cutting the tip of the protective hood of skin that covers the penis but does not damage the penis, the organ for sexual pleasure. Clitoridectomy damages or destroys the organ for sexual pleasure in the female."

Here, the author chooses to get into a comparison of the biological structure of the male and female genitals, and the amount of tissue cut, even though she has already established three clear human rights violations that take place at the outset for both sexes. She cites no medical references and makes over-simplified generalizations of anatomical analogies. Thus, she trivializes the circumcision procedure for males and promotes several misconceptions which will be refuted by the following:

1)The clitoris is not biologically equivalent to the penis and therefore clitoridectomy is not analagous to penisectomy ***(see Appendix I)***[8]

2) Male circumcision is medically unnecessary ***(see Appendix II***[9-10] ***and Appendix VII)***

3) Excision of the male foreskin is analagous to excision of the labia ***(see Appendix III)***[11-13]

4) Male circumcision damages the penis and has a high complication rate ***(see Appendix IV)***[14-18]

5) Male circumcision removes erogenous tissue ***(see Appendix V)***[19-20]

6) The penis is not primarily "the organ for sexual pleasure"; it serves two other important functions —urinary and procreative—and is primarily, the necessary organ for reproduction ***(Appendix I)***

7) Excision of the clitoris, while damaging the organ for sexual pleasure in the female, does not interfere with the ability of the female to procreate, as it is not an organ necessary for reproduction

Moving away from the comparison of the mutilation, the author then goes on to seemingly praise the male rite as a positive rite:

> "The content of male rites of passage is geared towards training young boys to develop skills associated with *power and control*, [our emphasis] not to reinforce their submissiveness and to make them feel they are second-class citizens as is done in the female initiation. Male circumcision is not perceived by African communities as a practice aimed at reducing the sexuality of men; on the contrary it is perceived as enhancing their virility."

The lack of awareness exhibited here is in the fact that the initiation of both boys and girls have a codependency.The males in the community cannot have power and control unless there is someone to be controlled. Equally, female submissiveness can only be reinforced if there is someone to be submissive ***to;*** i.e. someone (male) exerting *power and control*. And thus the controlled/controller cycle is maintained. Likewise reduction of sexuality of the female is juxtaposed to the myth of increased virility in the male. Article 5 of the *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)* understands the role this interrelated dynamic of superiority/ inferiority plays in the oppression of women and men, and recommends that:[21]

> "States Parties shall take all appropriate measures:
>
> "(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and **customary and all other practices *which are based on the idea of the inferiority or the superiority of <u>either</u> of the sexes*** . . ." [our emphasis]

Ritual male circumcision is a "customary practice" that reinforces the superiority of the male (in relation to the female and to uncircumcised males), even as female "circumcision" is a female rite that reinforces the inferiority of the female (in relation to the male). Uncircumcised males, males who "cry out" during the procedure and males who seek circumcision in a sterile (i.e. hospital) setting suffer ridicule and social ostracism ***(see Appendix VI).***[22-28]

In short—

**All genital mutilations stem from the same root: control. Whether it is to control sexual activity, sexual sensitivity, sexual virility, sexual appearance or sexual psyche, the male and female mutilations are interlocking practices. Both feed on the other's role as either controlled or controller, and both must be tackled, simultaneously. Nothing is to be gained by measuring the suffering of one sex against another and comparing wounds. Let both sexes be whole.**

## (B) Reasons of Religious Practice and Health

With the health risks and complications evident for those male children undergoing various forms of genital mutilation around the world, why has this issue not been raised earlier by a major body such as WHO or other UN-affiliate? If the issue *has* been raised and/or discussed what reasons were given for its non-inclusion as a global concern?

According to Sami Aldeeb (1994), the topic was apparently broached at the United Nations Seminar in Ouagadougou (Burkina Faso):

"During the . . . seminar . . . the majority of participants agreed that the justifications of female circumcision based on cosmogony and those based on religion 'must be assimilated to superstition and denounced as such' since 'neither the Bible, nor the Koran recommend that women be excised.' They recommend ensuring that, in the minds of people, male circumcision and female circumcision be dissociated, the former as a procedure for hygienic purposes, the latter, excision, as a serious form of assault on the women's physical integrity."[29]

The above statement brings to light the two main reasons promoted for the continued toleration of the male circumcision practice.

**(i) It is condoned and practiced systematically and routinely on infants/young children, by adherents to two major religions, Judaism and Islam. These religions are apparently seen as more legitimate than those tribal religions practicing FGM—the latter said to be based on "cosmogony" and relegated to "superstition."**

(This reason is supported by those who uphold the tradition on the grounds of the right to freely express and practice one's religious beliefs.)

**(ii) It is purported to promote good hygiene and provide preventive protection for specific diseases and infections.**

(This reason is promoted quite heavily by Western countries, such as the United States, in spite of the fact that these reasons have been reviewed and rejected by most paediatric/medical societies in English-speaking countries. ***(See Appendix VII)***

### (i) Freedom of Religion *vs.* Genital Integrity

The *Universal Declaration of Human Rights* guarantees the right to freedom of religious belief and practice in Article 18 as follows:

"Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance."[30]

The same Declaration closes with Article 30:

"Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein."[31]

The *Convention on the Rights of the Child* guarantees freedom of religion to the child as follows:

Article 14(1): "States Parties shall respect the right of the child to freedom of thought, conscience and religion."[32]

However, the right to religious freedom is qualified in Section (3) of the same Article:

"Freedom to manifest one's religion or beliefs may be subject only to such limitations are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others."[33]

**It can be concluded that religious freedoms are over-ruled only in circumstances where their practice infringes on the fundamental rights and freedoms of others.**

***Does the individual's fundamental right to physical and mental integrity take precedence over religious belief and practice if that religious practice is aimed at permanently altering the physical integrity of the individual?***

We return to the most recent definition of Female Genital Mutilation as cited from the World Health Organization (WHO):[34]

"Female Genital Mutilation (FGM), sometimes referred to as female circumcision, comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, ***religious*** or other non-therapeutic reasons."

*and without the sex distinction . . .*

"Genital Mutilation, sometimes referred to as circumcision, comprises all procedures involving partial or total removal of the external genitalia or other injury to the genital organs whether for cultural, ***religious*** or other non-therapeutic reasons."

Using recognized international human rights standards as a guide, we can conclude the following as concerns the right to religious practice as opposed to the genital integrity of children:

- **Genital Mutilation is practiced on the child for a number of reasons, including religious reasons or as part of religious practice**
- **Genital Mutilation, performed without the child's consent is a violation of the child's right to physical integrity**
- **This causes injury to the child and puts her/him at risk of morbidity and death, violating the *Convention on the Rights of the Child***
- **The religious practice to genitally mutilate the child is overruled by the fundamental right of the child to physical integrity.**
- **This fundamental right of the child not to be genitally mutilated is guaranteed to the child, regardless of their sex/gender**

## (ii) Health Reasons for Genital Mutilation of Males

Besides the general hygiene reason stemming from the belief that the uncircumcised penis is dirty and/or hard to keep clean (similar to beliefs regarding FGM), the following are the most common health reasons given for performing routine circumcision. They are, in brief, refuted herewith:

**Phimosis** *(This condition is not diagnosable until puberty; see Appendix II)*

### Prevention of Urinary Tract Infections

- The AAP reported that studies reflecting an increase in UTIs among intact boys are "retrospective," may have "methodologic flaws" and "may have been influenced by selection bias."[35]
- An occurrence of 1.1% of UTI in uncircumcised male infants is being used to justify the routine genital mutilation of 99% of healthy male newborns who do not develop UTIs.[36]
- UTIs occur more frequently in female infants than males.[37]Yet excision of the labia minora (the mucosa "skin" surrounding the entrance to the urethra of the female) is not recommended as a prevention. UTIs in female infants are treated with antibiotics.
- Rooming-in to facilitate close contact between newborns and their mothers is a suggested alternative to UTI prevention.[38] Natural immunization is accomplished via the transfer of aerobic and anaerobic flora from mother to infant.[39]

### Prevention of Cervical Carcinoma

> "The American Cancer Society . . . would like to discourage the American Academy of Pediatrics from promoting routine circumcision as preventative measure for . . . cervical cancer. The American Cancer Society does not consider routine circumcision to be a valid or effective measure to prevent such cancer. Research suggesting a pattern in the circumcision status of partners of women with cervical cancer is methodologically flawed, outdated and has not been taken seriously in the medical community for decades. Portraying routine circumcision as an effective means of prevention distracts the public from the task of avoiding the behaviors proven to contribute to . . . cervical cancer: especially cigarette smoking and unprotected sexual relations with multiple partners. Perpetuating the mistaken belief that circumcision prevents cancer is inappropriate."[40] ***(See Appendix VIII)***

### Prevention of Sexually Transmitted Disease

- The New York City Bureau of Venereal Disease Control issued a statement in 1979 that circumcision was of absolutely no value in preventing genital herpes infection.[41]
- A recent cross-sectional study of 300 consecutive heterosexual male patients attending a sexually transmitted diseases (STD) clinic showed that circumcision had no significant effect on the incidence of common STDs.[42]

**Prevention of Cancer of the Penis**

- The overall annual incidence of cancer of the penis in US men has been estimated to be 0.7 to 0.9 per 100,000 men.[43] In developed countries where neonatal circumcision is not routinely performed the incidence ranges from 0.3 to 1.1 per 100,000. This low incidence is half that found in uncircumcised US men.[44]
- The predicted lifetime risk of cancer of the penis developing in an uncircumcised man has been estimated at 1 in 600 men in the US; and 1 in 909 in Denmark[45] (where routine circumcision is not practiced.
- The predicted lifetime risk of cancer of the vulva in women (in the UK) is 1 in 400[46], considerably higher that that of penile cancer in men, yet routine excision of the labia of infant girls is not recommended as a preventive measure
- "The American Cancer Society . . . would like to discourage the American Academy of Pediatrics from promoting routine circumcision as preventative measure for . . . penile cancer. The American Cancer Society does not consider routine circumcision to be a valid or effective measure to prevent such cancer."[47] ***(See Appendix VIII)***
- "Fatalities caused by circumcision accidents may approximate the mortality rate from penile cancer."[48] "It is an incontestable fact . . . there are more deaths from circumcision each year than from cancer of the penis."[49]

## (C) Control of Sexuality

Western countries such as the United States, the UK, Australia, New Zealand, Canada and their dependant territories are the only regions where genital mutilation of male infants is routinely practiced for reasons of "health." This "medically-sanctioned" genital mutilation of male infants began in the 1800's when "circumcision" of children of both sexes was performed as a 'cure' for masturbation.[50]

> *[Removal of the clitoral hood or prepuce was "widely employed" in the United States between the late 1880s and 1937 to prevent masturbation[51]; and was occasionally used to stop masturbation in the 1940s and 1950s.[52] An estimated three thousand female circumcisions were performed annually in U.S. hospitals in the 1970s "to improve sexual response."[53] As late as 1973, female circumcision was suggested in a medical journal as a treatment for frigidity.[54] According to the World Health Organization, in 1976 the United States was the only medically advanced country in the world that practiced female circumcision[55]. Clitoridectomy—excision of the clitoris—was practiced in the United States between 1870 and 1910 to stop masturbation."[56]]*

The following quotes illustrate an intent to sexually control the male child—*not reasons of health*—as the real motivation behind routine circumcision. Pain was a deliberate accessory to the forced surgery and was designed to be registered in the child's psyche as "punishment."

> *"In cases of masturbation we must, I believe, break the habit by inducing such a condition of the parts as will cause too much local suffering to allow the practice being continued. For this purpose, if the prepuce is long, we may circumcise the male patient with present and probably with future advantages; the operation, too, should not be performed under chloroform, so that the pain experienced may be associated with the habit we wish to eradicate."[57]*

> *"(Clarence B.) was addicted to the secret vice practiced among boys. I performed . . . circumcision. He needed the rightful punishment of cutting pains after his illicit pleasures."[58]*

> *"I suggest all male children be circumcised. I am convinced that masturbation is much less common in the circumcised."[59]*

*"A remedy for masturbation which is almost always successful in small boys is circumcision . . . The operation should be performed by a surgeon without administering an anaesthetic as the brief pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment . . . The soreness which continues for several weeks interrupts the practice, and if it had not previously become too firmly fixed, it may be forgotten and not resumed."*[60]

This violent removal of a normal part of the genitals, *intentionally* "without administering an anaesthetic" so that pain can be *deliberately* inflicted, in order to "be connected with the idea of punishment" — "the rightful punishment of cutting pains after . . . illicit pleasures"—brings the roots of this whole practice squarely under the umbrella of human rights violations. Article 37 (a) of the *Convention of the Rights of the Child* states explicitly:

**"no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment . . ."**

Historical research proves that "medical" circumcision in the West—of both males and females—was practised with the primary motive of controlling sexuality.

This was not a new concept.

Moses Maimonides, the leading intellectual figure of medieval Judaism and a physician by profession, taught the following:[61]

*"As regards circumcision, I think that one of its objects is to limit sexual intercourse, and to weaken the organ of generation as far as possible, and thus cause man to be moderate. Some people believe that circumcision is to remove a defect in man's formation; but every one can easily reply: How can products of nature be deficient so as to require external completion, especially as the use of the fore-skin to that organ is evident. This commandment has not been enjoined as a complement to a deficient physical creation, but as a means for perfecting man's moral shortcomings. The bodily injury caused to that organ is exactly that which is desired. It does not interrupt any vital function, nor does it destroy the power of generation. Circumcision simply counteracts excessive lust; for there is no doubt that circumcision weakens the power of sexual excitement, and sometimes lessens the natural enjoyment; the organ necessarily becomes weak when it loses blood and is deprived of its covering from the beginning."*

As regards the control of women's sexual activity on this issue Maimonides notes:

*"Our Sages . . . say distinctly: It is hard for a woman, with whom an uncircumcised had sexual intercourse, to separate from him. This is, as I believe, the best reason for the commandment concerning circumcision."*

He then explains the rationale behind subjecting male infants to this *"very difficult operation"*:

*"This law can only be kept and perpetuated in its perfection, if circumcision is performed when the child is very young, and this for three good reasons. First, if the operation were postponed till the boy had grown up, he would perhaps not submit to it. Secondly, the young child has not much pain, because the skin is tender, and the imagination weak; for grown-up persons are in dread and fear of things which they imagine as coming, some time before these actually occur. Thirdly, when a child is very young, the parents do not think much of him; because the image of the child, that leads the parents to love him, has not yet taken a firm root in their minds. That image becomes stronger by the continual sight; it grows with the development of the child, and later on the image begins again to decrease and to vanish. The parents' love for a new-born child is not so great as it is when the child is one year old; and when one year old, it is less loved by them than when six years old. The feeling and love of the father for the child would have led him to neglect the law if he were allowed to wait two or three years, whilst shortly after birth the image is very weak in the mind of the parent, especially of the father who is responsible for the execution of this commandment. The circumcision must take place on the eighth day . . ."*

# PART 3
# MALE GENITAL MUTILATION AS A RECOGNIZED HUMAN RIGHTS VIOLATION

As an unnecessary surgical procedure, carrying serious inherent risks and exhibiting a history of documented complications, routine male circumcision—along with other forms of genital mutilations (performed for reasons of culture, religion, sexual control as well as for unproven health reasons)—has long been recognized as a human rights violation. The following competent examples serve to illustrate this fact.

## (A) THE CHARTER FOR CHILDREN IN HOSPITAL (1959)[62]

Section 5 of the Charter for Children in Hospital reads as follows:

" . . . Every child shall be protected from unnecessary medical treatment and investigation."

## (B) INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (1966)[63]

Article 7 of the ICCPR reads as follows:

"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. *In particular, no one shall be subjected without his free consent to medical or scientific experimentation.* [our emphasis]

## (C) THE CONVENTION ON THE RIGHTS OF THE CHILD (1989)[64]

Several articles of the Convention on the the Rights of the Child address the child's right to physical and mental integrity, optimal health and the right to be protected from torture or other cruel, inhuman or degrading treatment. The respective articles are as follows:

**Article 19(1)**
"States Parties shall take all appropriate legislative, administrative, social and educational measure to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitations, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child."

**Article 24**
"1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health . . .

"2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures

"a to diminish infant and child mortality . . .

"3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."

Article 37 a
"a. No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment . . ."

## (D) U.N. RECOGNITION OF MALE GENITAL MUTILATION AS TORTURE

Two United Nations documents were located that record and recognize varying forms of sexual assault/sexual mutilation of males—including non-medical circumcision—as torture.

*The Fourth Report on War Crimes in the Former Yugoslavia (Part II)* reports the following under the headline "Torture of Prisoners", August-September 1992:[65]

"A U.S. surgeon from California spent 2 weeks in Bosnia-Herzegovina (including time at Kosevo hospital in Sarajevo) in late August and early September performing remedial urological surgery.

"The doctor reportedly found that Muslim and Mujahedin irregular troops—some from Afghanistan and Saudi Arabia—had routinely performed crude, disfiguring, non-medical circumcisions on Bosnian Serb soldiers, and he treated one 18-year-old Bosnian Serb soldier who was so brutally circumcised that eventually the entire organ required amputation. (Department of State)"

On 6 October 1992, the Security Council requested the Secretary General to establish a Commission of Experts to examine and report on violations of international humanitarian law committed in the territory of former Yugoslavia. *The Commission of Experts' Final Report (S/1994/674)* established that universal jurisdiction existed for "crimes against humanity" which were considered to be "elementary dictates of humanity to be recognized under all circumstances"; applicable "to all contexts"; and "no longer dependent on their linkage to crimes against peace or war crimes."

These "crimes against humanity", the Report established, include "violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; taking of hostages; outrages upon personal dignity, in particular humiliating and degrading treatment . . ."[66]

The Report later addresses **rape and other sexual assaults** as crimes under international humanitarian law:

"Unlike most codified penal laws in the world, in international humanitarian law rape is not precisely defined. But on the basis of the contemporary criminal laws of the world's major criminal justice systems, the Commission considers rape to be a crime of violence of a sexual nature against the person. *The characteristic of violence of a sexual nature also applies to other forms of sexual assault against women, men* and children, when these activities are performed under coercion or threat of force and include sexual mutilation. It should be noted that* irrespective of their definition, *acts of sexual assault against women, men and children* are prohibited by international humanitarian law *through normative provisions prohibiting violence against the physical integrity and dignity of the person.* Therefore, rape and other sexual assaults are covered in pari materia."[67] [our emphasis]

*The asterisk next to "men" in the text leads us to a footnote (18) which reads as follows:

"Violent crimes of a homosexual nature are not explicitly mentioned in international humanitarian law, ***but protection against rape and other sexual assaults is also applicable to men on the basis of equality and non-discrimination.*** " [our emphasis]

Two paragraphs further on, the Commission also makes the strong statement that **"rape and other sexual assaults" constitute "torture or inhumane treatment"** which wilfully cause "great suffering or serious injury to body or health." [our emphasis]

In Part IV of the *Commission's Final Report*, the nature of sexual assault or abuse of men is detailed as follows:[68]

"There have also been instances of sexual abuse of men as well as castration and mutilation of male sexual organs . . ."

"Men are also subject to sexual assault. They are forced to rape women and to perform sex acts on guards or each other. They have also been subjected to **castration, circumcision or other sexual mutilation."** [our emphasis]

"Sexual assaults were also practised against men: one witness saw prisoners forced to bite another prisoner's genitals."

"Another incident related in an interview involved prisoners lined up naked while Serb women from outside undressed in front of the male prisoners. If any prisoner had an erection, his penis was cut off. The witness saw a named Serb woman thus castrate a prisoner. Another ex-detainee told of suffering electric shocks to the scrotum and of seeing a father and son who shared his cell forced by guards to perform sex acts with each other."

"Castrations are performed through crude means such as forcing other internees to bite off a prisoner's testicles."

## (E) GENITAL MUTILATION AS A HUMAN RIGHTS VIOLATION IN THE SUDAN

Genital Mutilation in the form of circumcision is also reported as a human rights violation in the Sudan where both Dinka boys and girls are abducted and sold into Arab slavery. Forced circumcision is practiced on these children as a part of efforts to force them into adopting the Islamic religion.

In their "Witness to Slavery" Series, reporters Gilbert A. Lewthwaite and Gregory Kane publish their experiences of buying and freeing two young Dinka boys after six years of bondage:

" . . . a dozen children, all boys, are ushered forward from the shade of another tree . . .We survey the children. Most have rust-tinted hair, the ubiquitous sign of malnutrition in this land of unending need. The dust of Sudan is caked on their black bodies. Some have bruises and scars to attest to their maltreatment. *Some, we learn, were forcibly circumcised in the Islamic tradition."* [69][our emphasis]

## (F) THE WORLD MEDICAL ASSOCIATION

The World Medical Association is currently looking into the ethical and human rights issue of male genital mutilation:

"The World Medical Association does not have an official declaration regarding routine male circumcision, but we are in the process of investigating this practice."[70]

**There exists ample evidence of mutilation of the male genitals for non-medical reasons to illustrate its status as a human rights violation. It is only a matter of time before full recognition is achieved. What remains clear is that the right of either sex not to be genitally mutilated is enshrined in the indivisibility and equal application of universal human rights standards, even when not specifically mentioned.**

# PART 4

## A. CASE STUDY: "A BOY WITHOUT A PENIS"

"A Boy Without A Penis"[71] ***(see Case Study A. at the end of this report)*** tells the story of an eight-month-old twin boy who "had his penis accidentally burned to ablation" during a routine circumcision procedure to correct "phimosis." Recommendation was subsequently made to the parents by consultants at John Hopkins Hosptial, Baltimore, Maryland, to subject the child to sex-change surgery. This is "the standard in instances of extensive penile damage to infants." To accomplish this he was fully castrated (testicles were surgically removed, or excised) and a "vagina" constructed. After a physically, behaviourly and emotionally traumatic childhood culminating in a suicide attempt, "Joan" was finally told the truth about what had been done to "her", at which time "she" requested to be changed back into a male. What continued to be heralded as a successful procedure in the medical text-books was only recently exposed as a complete failure and trauma for what had been originally a perfectly normal child.[72]

### The Human Rights Violations Occurring in This Case

1) The infant—because of his gender—was subjected at eight-months-old to a medically unnecessary surgery. (Phimosis we have learned cannot be diagnosed in an infant, whose foreskin is naturally attached to the glans). This surgery exposed him to inherent health risks. **[A violation of Article 5 of the Charter for Children in the Hospital and Article 24 of the Convention on the Rights of the Child.]**

2) The medically unnecessary operation was typically performed without an anesthetic (1960s) without any consideration for pain and suffering. **[A violation of Articles 19(1) and 37(a) of the Convention on the Rights of the Child.]**

3) The sex change operation further violated these same Articles, and because it was a medical 'experiment' (it was not known whether children would 'take' to being sexually altered) this was a **direct violation of Article 7 of the International Covenant on Civil and Political Rights.**

4) Female infants were not subjected to similar unnecessary routine surgery. **[A violation of Article 2 of the Universal Declaration of Human Rights and Article 2 of the Convention on the Rights of the Child, both which prohibit distinction of sex in the application of human rights and guarantee equal protection of physical and mental integrity.]**

5) He was deliberately deprived of his procreative abilities (having his testicles surgically removed) which violated his right to "found a family" **[provided for by Article 16 of the UDHR].**

The list could go on.

**This child suffered several human rights violations which were enacted upon him simply because he was born male—*because he had a penis.* Excising the labia of a female child in the same country, would be illegal and would not be tolerated. Who will tell this child that the routine and unnecessary mutilation of his genitals is not a human rights violation, simply because he is by nature male, and therefore not protected by reason of his gender?**

## B. CASE STUDY—THE AMA-XHOSA OF SOUTH AFRICA

In one study of the penile mutilation practice or circumcision of the Xhosa tribe of South Africa a documented 9% of the mutilated boys died; 52% lost all or most of their penile shaft skin; 14% developed severe infectious lesions; 10% lost their glans penis; and 5% lost their entire penis.[73] ***[See: "Ritual Circumcision (Umkhwetha) amongst the Xhosa of the Ciskei"—Case Study B.]***

Local newspapers continue to faithfully record news of deaths, infections, coerced circumcisions and violence accompanying circumcision festivities, every year.[74] ***(see Case Study B.)***

Lumka Sheila Funani, a Xhosa nurse who put aside "her normal Xhosa constraints which make the subject taboo to women" —out of concern for boys in her community—documents the following:[75]

> " . . . in Xhosa tradition an uncircumcised male cannot inherit his father's possessions, nor can he establish a family. He cannot officiate in ritual ceremonies. In fact there is no such thing as an 'uncircumcised man' in Xhosa society. A Xhosa who is not circumcised is described quite simply as a boy, an *inja* (dog), and an *inqambi* (unclean thing) . . . So uncompromising are the Xhosa people on this that no Xhosa woman would knowingly and willingly marry an uncircumcised Xhosa male."
>
> "The feeling is so strong that an uncircumcised male past circumcision age may be overpowered by a group of men and circumcised against his will. This does not happen only with the Xhosa. Recently in Lebowa respectable citizens—school principals, inspectors, etc.—were suddenly forcibly circumcised. In Kwa Ndebele an uncircumcised male was made member of the cabinet; the Ndebele would have none of it. They forcibly circumcised him . . . Around 1987 the Pedi rounded up a whole lot of males, among them a school principal, and circumcised them."[76]

The attachments speak for themselves. To attempt to annotate the human rights violations here would be wearying—they are self-evident. Female Genital Mutilation is not practised by the Xhosa.

**The one point to be stressed here is that, if it is a human rights violation for an adult male to be restrained and forcibly circumcised, then it is even more of a violation for a child too young to protect himself and, therefore, even more vulnerable to exploitation.**

## C. CASE STUDY—AMPUTATION OF THE GLANS PENIS IN JEWISH RITUAL CIRCUMCISION

Following the attachments on the Xhosa, is ***Case Study C.***—"Circumcision: Successful Glanular Reconstruction and Survival Following Traumatic Amputation"—which documents 7 cases of traumatic amputation of the glans penis, of which 6 were 8-day-old Jewish infants undergoing ritual circumcision.[77] The basic human rights violations are similar to ***Case Study A.***, although without the tragic result of losing the entire anatomy and consequently being subjected to radical sex change surgery.

In ritual circumcision for religious reasons, the child is permanently disfigured, genitally, because of the religious beliefs of the parents, thereby—in addition to the physical violation—taking away the right to formulate his own religious beliefs; a right guaranteed by Article 14 (1 & 3) of the *Convention on the Rights of the Child.*

**If these were little girls, whose labia minora were being excised, would we see such unnecessary surgery and health risk—in the name of religious belief—as a human rights violation?**

# PART 5
# THE AMNESTY INTERNATIONAL STATUTE:
## *Clarifying the Powers and Limitations of the International Council*

*"Except as otherwise provided in the Statute* the International Council Meeting shall make its decisions by a simple majority of the votes cast."[78] (Article 19)

**Notations from Robert's Rules of Order on the Limitations of an Assembly[79]**

**§ 2. Rules of an Assembly or Organization**
(Page. 12): "The bylaws, by their nature, necessarily contain whatever limitations are placed on the powers of the assembly of a society (that is, the members attending a particular one of its meetings) with respect to the society as a whole. Similarly, the provisions of the bylaws have direct bearing on the rights of members within the organization—whether present or absent from the assembly."

**§ 10. The Main Motion**
**Main Motions That Are Not in Order**
(Page 91): "1) No main motion is in order which conflicts with national, state, or local law, or with the bylaws (or constitution) or rules of the organization or assembly. **If such a motion is adopted, even by a unanimous vote, it is null and void."**

**§ 55. Bylaws: Content and Composition of Bylaws**
**Nature and Importance of Bylaws**
(Page 475): "The content of a society's bylaws has important bearing on the rights and duties of members within the organization—whether present or absent from the assembly—and on the degree to which the general membership is to retain control of, or be relieved of detailed concern with, the society's business. **Except as the rules of a society may provide otherwise,** its assembly (that is, the members attending one of its regular or properly called meetings) has full and sole power to act for the entire organization, and does so by majority vote. Any **limitation** or standing delegation of the assembly's power with respect to the society as a whole **can only be by provision in the bylaws**—or in the corporate charter or separate constitution if there are either of these."

As illustrated above by examples from Robert's Rules of Order, there are limitations on the General Assembly's decision-making powers. Specifically where a decision is adopted which is in conflict with the organization's constitution or statute, that decision can be called into question and rendered meaningless.

In relation to the human rights violation of genital mutilation, the following examines the distinctions which are prohibited by the Amnesty International Statute and how exclusive they would be if adopted:

## THE HUMAN RIGHTS VIOLATION OF GENITAL MUTILATION

Samples of Distinctions That Would be in Direct Conflict with the AI Statute (not exhaustive):

1) ETHNIC ORIGIN (RACE): e.g. ***African* Genital Mutilation**
- This resolution title would mean that Amnesty would only recognize the genital mutilation of persons of African origin as a human rights violation.

2) SEX: e.g. ***Female* Genital Mutilation**
- This would mean that Amnesty would only recognize the genital mutilation of persons of the female gender as a human rights violation.

3) COLOUR: e.g. ***Black* Genital Mutilation**

- This would mean that Amnesty would only recognize the genital mutilation of persons whose skin colour is considered "black" as a human rights violation.

4) LANGUAGE: e.g. ***Xhosa* Genital Mutilation**

- This would mean that Amnesty would only recognize the genital mutilation of persons who spoke the Xhosa language as a legitimate human rights violation.

5) RELIGIOUS BELIEF: e.g. ***Islamic* Genital Mutilation**

- This would mean that Amnesty would only recognize the genital mutilation of persons who are of the Muslim faith as a human rights violation.

All of the above adjectives (in ***italics***) describe the human rights violation of "genital mutilation" with a qualifying distinction; are discriminatory by their very nature; and have the effect of *excluding* persons outside the sphere of the qualifying distinction:

e.g.: ***"African"*** excludes all persons of other ethnic origins.

***"Female"*** excludes all persons of the male gender.

***"Black"*** excludes all persons whose skin colour may be brown, white, yellow or red.

***"Xhosa"*** excludes all persons whose language is different, eg. Zulu, Bambara, Arabic.

***"Islamic"*** excludes all persons of another religious belief, eg. Christian, Jewish, Animist.

Because the bylaws or *Statute of Amnesty International* distinctly prohibit discrimination by ethnic origin, sex, colour, language, religious belief, etc., in the defense of human rights violations adopted by its mandate, the International Council Meeting has no power to present a resolution making such a distinction; and, in this regard, such a resolution is "out of order." A vote taken on such a resolution—whether unanimous or not—is in direct conflict with the provisions of the *Statute*, and is therefore "null and void." In order for such a motion to be "in order" only the human rights violation should be cited: i.e. "Genital Mutilation."

**Conversely, if a resolution designed to correct such a distinction or discrimination is rejected by the Council Meeting, essentially the Meeting is voting to uphold a distinction in direct conflict not only with the provisions of the Statute, but with the Universal Declaration of Human Rights. Such a negative vote, whether unanimous or not, could be pronounced as "null and void" or outside the provisions of the Statute.**

This then would acknowledge and give credibility to the following essential parts of the AI Statute

1) ". . . the obligation on each person to extend to others rights and freedoms equal to his or her own . . ."

2) ". . . awareness of and adherence to the *Universal Declaration of Human Rights* . . ."

3) ". . . the indivisibility and interdependence of all human rights and freedoms . . ."

4) ". . . the rights of *every person* . . . to be free from discrimination and . . . the right of *every person* to physical and mental integrity . . ." [80][our emphasis]

**The Bermuda Section maintains that the provisions of the Statute—based primarily on its object and mandate—govern the International Council Meeting, not the other way around. The International Council Meeting is bound by the principles of the Statute of Amnesty International.**

## CONCLUSION

After the International Council Meeting in South Africa, December 1997—with regard to the Bermuda Resolution A3.6 ("Gender Distinction in Genital Mutilation")—the following was reported in the "Report and Decisions" of the 1997 ICM (AI Index: ORG 52/02/98), page 38:

*During the plenary, AI Bermuda sought clarification from the IEC regarding whether the subject matter of this resolution would fall within the remit of Decision 5, Abuses by Non-State Actors, and Decision 20, Promotional Work.*

*The IEC replied that this could connect with the definition of promotional work in Decision 20* ***if male genital mutilation were considered to represent a violation of internationally recognized human rights standards.*** [our emphasis]

AI Bermuda was invited to prove that this was the case.

Amongst other things, this report establishes the following:

**1) The United Nations recognizes sexual assault of women, men and children as a human rights violation (page 15).**

**2)** This same body recognizes sexual mutilation—**including castration and circumcision—as a form of sexual assault (page 16).**

**3)** The United Nations has stated that rape and other sexual assaults ***constitute torture or inhumane treatment (page 15).***

**4)** That same body has also declared that with regard to sex distinction, whilst violent crimes of a sexual nature against males may not be explicitly mentioned in international humanitarian law, **protection against... sexual assaults is also applicable to men on the basis of equality and non-discrimination (page 15).**

**This position is supported by the ICCPR, CRC and other documents cited in Part 3 of this report and leaves no doubt that Male Genital Mutilation represents a violation of internationally recognized human rights standards.**

## REQUEST

The International Council Meeting pronounced "Female Genital Mutilation" a human rights violation. This creates an ***"obligation"***—the word provided by Article 1 of the *Statute of Amnesty International*—for the organization "to extend to others" those same "rights and freedoms". "Others" in this case is, by definition, those persons who are *not* female: i.e. **males.** The right and freedom, in this case, is the right and freedom not to be genitally mutilated.

**In keeping with the foregoing, the Bermuda Section requests the International Executive Committee to advise the Section and the international membership that the International Council Meeting has no power to "vote to uphold" a distinction prohibited by our Statute, and that, accordingly, the vote taken on the Bermuda resolution A3.6 at the 1997 International Council Meeting, is "null and void." The Section also requests that an official statement be released acknowledging the genital mutilations of all persons, including males, as human rights violations; and that it be acknowledged that the Section may do promotional work on this issue.**

## APPENDIX I

The penis of the male is not the "biological equivalent" of the clitoris. In the developing male fetus, what becomes the complete penile organ is comprised of the "genital tubercle" (pre-clitoris in the female), the "urethral orifice" (which is separate from the clitoris in the female) and the "urogenital folds" (the labia minora in the female). These three organs—which remain separate in the female—literally fuse together to create the complete penile organ *(see illustration on following page)*.[8]

The penis, then, is actually the biological equivalent of the entire female vulva (clitoris, urethral orifice & labia minora) with the exception of the labia majora, which are the equivalent to the male scrotum. Penisectomy, then is not the equivalent of clitoridectomy, but of removal of, essentially, the entire vulva (including the clitoris), with the exception of the labia majora.

In addition to the above, as the organ of procreation, the penis provides—via the urethra—for the expulsion of the male reproductive fluids (semen) containing sperm.

## APPENDIX II

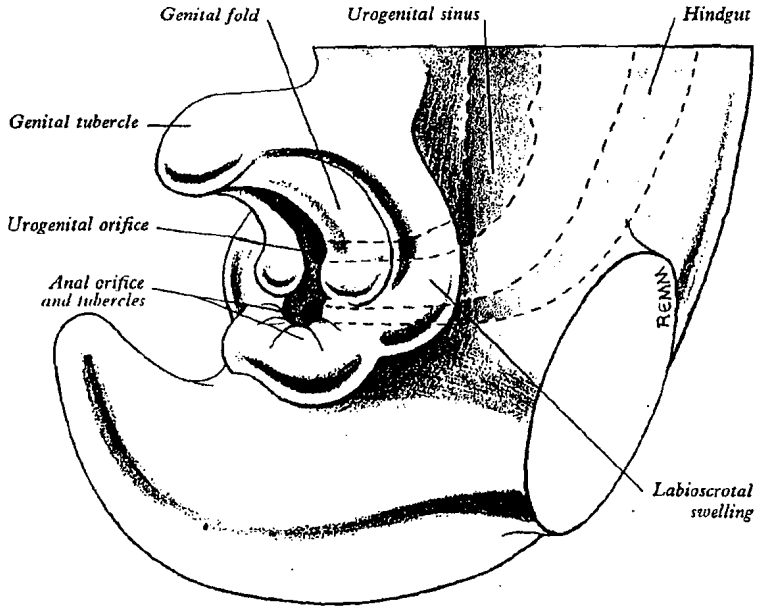
Abraham M. Rudolph, editor of the 18th edition of *Pediatrics*,[9] documents: "The prepuce, foreskin, is normally not retractile at birth . . ."

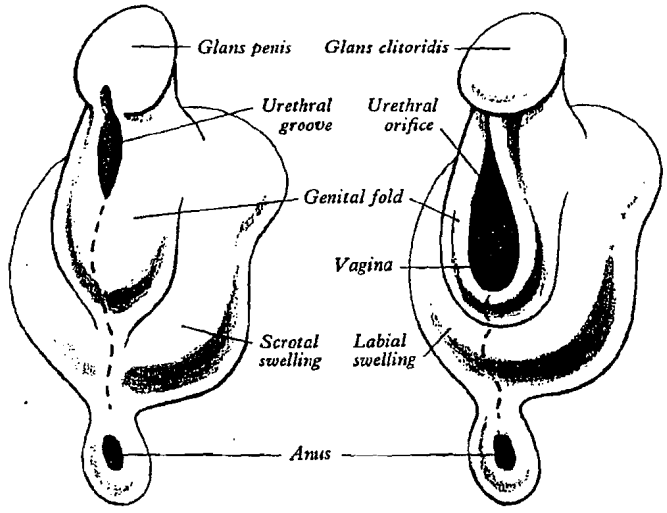
The non-retractible prepuce at birth is a completely, normal, natural condition. In fact, *Gray's Anatomy* (cited above) makes it clear that the preputial sac (which helps to free the prepuce from the surface of the glans) is still in the developmental stage at birth. "The preputial sac may not be complete until 6-12 months or more **after birth** . . ." [10][*Gray's* emphasis]

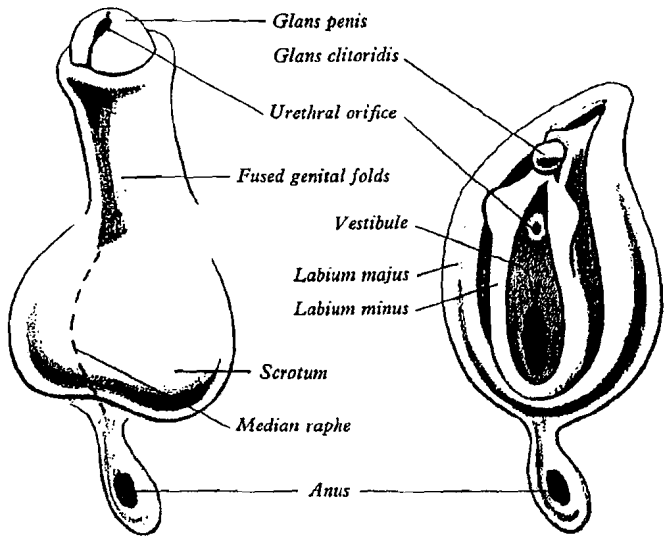
The quote from *Pediatrics* continues:

"The ventral surface of the foreskin is naturally fused to the glans of the penis. At age 6 years, 80 percent of boys still do not have a fully retractile foreskin. By age 17 years, however, 97 to 99 percent of uncircumcised males have fully retractile foreskin. Natural separation between the glans and the ventral surface of the foreskin occurs with the secretion of skin oils and desquamation of epithelial cells, smegma. At puberty, the secretions of specialized sebacious glands, Tyson's glands, assist in completing the separation between the glans and foreskin; in adulthood they protect and lubricate the glans penis and inner layer of foreskin. No treatment is required for the lumps of smegma, and in particular, there is no indication ever for forceful retraction of the foreskin from the glans. Especially in the newborn and infant, this produces small lacerations in addition to a severe abrasion of the glans. The result is scarring and a resultant secondary phimosis. Thus, it is incorrect to teach mothers to retract the foreskin forcefully."

**It must be noted here that practically every male child who has been circumcised for "phimosis", unless he was at the age of puberty, has had a natural condition diagnosed as a disease by misguided doctors; or worse, has had the disease develop as a direct result of ill-advised parents attempting to forcibly retract the foreskin.**


Genital fold
Urogenital sinus
Hindgut
Genital tubercle
Urogenital orifice
Anal orifice and tubercles
RECTUM
Labioscrotal swelling


Glans penis
Glans clitoridis
Urethral groove
Urethral orifice
Genital fold
Vagina
Scrotal swelling
Labial swelling
Anus


Glans penis
Glans clitoridis
Urethral orifice
Fused genital folds
Vestibule
Labium majus
Labium minus
Scrotum
Median raphe
Anus

# APPENDIX III

In Appendix I, we described how the penis develops by the fusing of what becomes clitoris-urinary orifice-labia minora in the female. Here we describe in more detail the fate of the urogenital folds (labia minora in the female) in the development of the urethra and foreskin in the male.

"The genital folds fuse with each other from behind forwards enclosing the phallic part of the urogenital sinus behind to the form the bulb of the urethra; similarly, the folds close the definitive urethral groove in front to form the greater part of the spongiose urethra. . . Thus, as the phallus lengthens, the urogenital orifice is carried onwards until it reaches the base of the glans."[11]

In other words, the genital folds fuse and embrace the urethral opening, elongate down the whole length of the phallus (forming the full-length urethra), culminating at the tip of the glans.

"If the fusion of the urethral folds fail to progress distally on the ventral penis, the urethra will be shortened."[12] This condition is called hypospadias and occurs in 1 in 500 male infants. "It is an abnormality resulting from a failure of the urethral folds to fuse completely over the urethral groove. The ventral foreskin also is lacking, while the dorsal portion give the appearance of a hood."[13]

The absent ventral foreskin which occurs as a result of the incomplete fusion of the genital folds testify to the part that the genital folds play in the formation of the foreskin of the male. The urethral orifice and the urogenital folds are indelibly linked and literally move together. Just as the genital folds (labia minora) embrace the urethral orifice of the female and extend to just above the clitoris, forming the clitoral hood or prepuce, so the genital folds in the male anatomy fuse to carry the urethral orifice lengthwise to the tip of the penis and then form the protective foreskin.

***Labia minora:*** *thin delicate folds of . . . skin . . . divided anteriorly to form upper and lower folds that fuse around the clitoris—an upper prepuce of the clitoris and a lower frenulum of the clitoris. United posteriorly by a fold, the frenulum.*
***Prepuce (foreskin):*** *a hoodlike fold of skin that covers the glans, is connected to the glans below the urethral orifice by a fold, the frenulum.*
(Definitions from: http://nba19.med.uth.tmc/edu/academic/devo/html/pelvis-perineum.htm#male)

The foreskin or prepuce of the male is homologous to the labia minora of the female. Excision of the foreskin or prepuce—"circumcision"—is analagous to excision of the labia minora.

# APPENDIX IV

Routine non-medical circumcision is designed to induce a deliberate injury to a normal prepuce. ***(See table on following page.*** Taken from Holman, Lewis & Ringler 1995. "Neonatal Circumcision Techniques." *American Family Physician*, August 1995, pages 511-518.) This premeditated injury and destruction of normal tissue is considered a 'normal procedure' in many countries.

Complications arising from the unnecessary circumcision procedure are very real. Perhaps the most recent and most detailed study of these complications was done by Williams and Kapila (1993).[14] They estimate a complication rate of between 2-10 percent. This is the rate for Western countries where circumcisions are either performed in the hospital or by a Jewish mohel in a home setting (i.e. in sanitary conditions). This estimate of complications excludes those innumerable circumcisions which take place in the unsanitary settings of non-Western countries—settings practically identical to those where female genital mutilation takes place.

# Circumcision is Designed to Cause Injury to a Normal Prepuce

## Circumcision Techniques

The following are three most commonly used procedures of circumcision techniques showing procedure, characteristics, advantages and disadvantages:

*TABLE 1*

**Comparison of Circumcision Techniques**

| *Procedure* | *Characteristics* | *Advantages* | *Disadvantages* |
|---|---|---|---|
| Mogen clamp | Induces crush injury to prepuce while shielding genitalia<br>Prepuce surgically removed | Speed<br>Less complicated to perform<br>Instant result | Least commonly used technique<br>Fewer experienced operators |
| Gomco clamp | Induces crush injury to prepuce while shielding genitalia<br>Prepuce surgically removed | Instant result with good cosmesis<br>Widely used<br>Customized fit possible for each infant | Higher rate of shaft denudation<br>More time intensive<br>More complicated to perform |
| Plastibell device | Induces crush injury to prepuce while shielding phallus<br>Prepuce sloughs away along with plastic shield in three to seven days | Ease of use<br>Widely available | Slightly higher incidence of infection<br>Final result not immediately apparent |

**Circumcision is designed to cause injury to the penis by inducing "crush injury" to the normal, protective prepuce, and then excising it. This "foreskin amputation" is considered a normal surgical procedure in some countries and is traditionally and typically performed without anesthesia on male infants who are just days old.**

Review

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# Complications of circumcision

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*Circumcision remains a common operation, with over 30 000 procedures performed annually in the UK, mostly on children. The British Medical Association has recommended that circumcision should be performed only for medical reasons. Despite this, controversy exists over whether too many circumcisions are being performed. Are patients being exposed to an unnecessary operation? It may be argued that in doubtful cases it is easier to proceed to circumcision on the assumption that the attendant risks are low, but the operation is associated with a definite morbidity and rare deaths have been reported. This review considers the spectrum of complications that may result from circumcision and discusses the possible aetiological mechanisms.*

Circumcision is probably one of the oldest of all surgical procedures. Although the origin of the practice is not entirely clear, it almost certainly began as a religious rite. That it was practised by the Egyptians is evident as the earliest mummies were found to be circumcised. In the Jewish community circumcision remains a religious ritual and is usually performed on the child's eighth day of life by a *Mohel*. Religious circumcision is also practised by Muslims; the procedure is performed between the ages of 4 and 13 years. Curiously, however, the Koran contains no specific ordinance on this subject. Currently, approximately one-sixth of the world's male population is circumcised, mostly on religious grounds. In Western society circumcision is usually performed for medical reasons, the commonest of which is phimosis[1–3]. There is, however, enormous variation between the circumcision rate in the UK (5–6 per cent[1,4]) and that in the USA (80–90 per cent[5–7]). This large discrepancy exists despite recommendations from both the British Medical Association[8,9] and the American Association of Pediatricians[10] that circumcision should be performed only for medical reasons.

The aim of circumcision is to excise sufficient foreskin (both penile shaft and inner preputial epithelium) to leave the glans uncovered. As an alternative to circumcision some advocate the technique of 'preputial plasty', where a longitudinal incision of the phimosis constricting band is followed by transverse suture[11]. Apparently more popular in Europe, it is a method that has yet to find favour among surgeons in the UK. There are many different techniques of circumcision but they can be broadly classified into four types: dorsal slit, shield, clamp and excision[12]. All these techniques have their strengths and limitations together with their protagonists and critics. More often than not, however, complications arise as a result of operator inexperience rather than of the method employed. All techniques aim to provide the best cosmetic result together with the lowest possible morbidity rate; in this respect the key factors to be observed are attention to asepsis, adequate but not excessive excision of the inner and outer preputial layers, haemostasis and cosmesis[12]. Some authors have reported a complication rate as low as 0·06 per cent[13], while at the other extreme rates of up to 55 per cent[14] have been quoted. This reflects the differing and varying diagnostic criteria employed; a realistic figure is 2–10 per cent[3,12,15]. Although haemorrhage and sepsis are the main causes of morbidity, the variety of complications is enormous. The literature abounds with reports of morbidity and even death as a result of circumcision.

## Operative complications

Haemorrhage and sepsis are the commonest complications and are considered in greater detail below. The nature of circumcision dictates that errors of omission and commission, i.e. too little or too much, in assessing how much foreskin to remove are likely to happen, and one of the commonest complaints is of an unsatisfactory cosmetic result. If insufficient foreskin is removed the cosmetic appearance is such that the penis does not appear to have been circumcised; phimosis may still subsequently develop. In a series of consecutive circumcisions in Australia, Leitch[16] found that in 9·5 per cent of patients the operation had to be repeated because of inadequate skin excision at the initial procedure. MacCarthy *et al.*[17] reported this figure to be 1 per cent in a study from the UK. In a more recent series from Israel, where religious circumcision is widespread, of 60 children referred following potentially inadequate circumcision 42 required recircumcision; the majority of these children were operated on before 4 years of age[18]. The rest were treated conservatively and had a satisfactory cosmetic result at follow-up to 10 years of age. Insufficient excision of the foreskin and inner preputial epithelium may result in wound contraction and cicatrization of the distal foreskin. The fibrotic ring so produced may result in true phimosis, an event observed in 2 per cent of cases in one UK series[15]. In severe cases urinary obstruction may ensue[19].

Removal of too much skin from the penile shaft may be caused by pulling it over the glans during operation. After foreskin excision the remaining skin slides back, leaving a denuded shaft. Others suggest that such penile denudation injuries occur as a result of failure to break down the ventral foreskin adhesions to the glans penis completely[12,20]. It is therefore essential that, before any incision is made, the inner preputial epithelium is completely free from the glans such that the entire coronal sulcus can be visualized. Penile denudation injuries may occur as a result of sepsis[21], from diathermy injury[22] or from injected substances mistaken for anaesthetic solutions[22]. The majority of cases can usually be managed conservatively with a satisfactory cosmetic and functional outcome[21,23–25]. Such injuries in adults may be managed conservatively if the defect is less than half of the total penile skin. Complete denudation in the adult is managed by split-thickness skin grafting for optimum cosmetic and functional results[21,23,26]. Of three cases encountered by Gee and Ansell[24], one child with complete denudation had initial treatment by burial of the penis in a tunnel of scrotal skin; no follow-up was available on this patient. Use of a pedicled scrotal skin flap has recently been described for the reconstruction of penile shaft skin[27].

A rare consequence of excision of excess preputial skin is the so-called 'concealed penis'[23,25,28,29]. Kaplan[12] maintains that, although an excess of skin is removed, not enough inner preputial epithelium is excised. The new preputial orifice is,

therefore, distal to the glans, and as healing and fibrosis occur the penile shaft is forced into the suprapubic fat, with the resulting preputial ring at the level of the skin of the *mons pubis*. Other suggestions about the aetiology of this complication include a tendency of the penis to retract into the fatty mons pubis[29] and the possibility that the penile shaft is forced into a subcutaneous position by wound contraction[25]. Subsequent fibrosis of the circumcision wound leads to stenosis of the preputial orifice, which then traps the penile shaft subcutaneously[23,29]. Treatment of this condition is surgical correction. In the presence of phimosis, Kaplan[12] recommends a circumferential incision at the preputial ring to avoid the need for skin grafts to achieve coverage of the penile shaft. A vertical incision caudal to the circular scar was used by Kon[29] to expose the glans and penile shaft which was in a subcutaneous position, tightly adherent to the surrounding tissue. Nearly complete direct skin coverage was achieved, apart from a small ventral defect, which was covered by rotation of the scrotal skin. A vertical incision was used also by Byars and Trier[23], and, while Shulman *et al.*[25] did not state the incision employed, both required the use of skin grafts for coverage of the penile shaft. More recently, Radhakrishnan and Reyes[30] chose to use opposing U shaped incisions and so doing were able to obtain skin coverage with vascularized flaps: they contend that the functional and cosmetic results are superior to those of reconstruction with split-thickness grafts, which may result in comparatively inelastic skin on the penile shaft.

Many other forms of surgical mishap have been reported. Laceration to the penile skin and scrotum resulting in exposure of both testes as reported by Shulman *et al.*[25] was managed by primary suturing. Laceration of the penile shaft with resultant partial amputation has also been described[23]. Total ablation of the penis may occur as a result of diathermy injury[31] and loss of the penis from the use of a rubber band as a tourniquet has been reported[32]. Injury to the glans may result from inadequate separation of preputial adhesions. Glandular injury may be of varying severity and cases of complete surgical amputation of the glans have occurred[23]. McGowan[33] described a case in which inadvertent placement of scissors into the urethra while attempting a dorsal slit resulted in surgical bivalving of the glans.

## Non-operative complications

Ruff *et al.*[34] described a case of myocardial injury following immediate postnatal circumcision. This was confirmed by a raised level of type MB creatine kinase and by left ventricular posterior wall hypokinesis on echocardiography. It was concluded that the exposure of the child to cold stress as a result of circumcision resulted in a persistent fetal circulation and hypothermia. The neonate had a satisfactory outcome on medical management. A case of recurrent pneumothorax following circumcision was reported by Auerbach and Scanlon[35] in a neonate. The circumcision was complicated by moderate bleeding and the baby's distress was sufficient to produce circumoral cyanosis and persistent tachycardia. It was concluded that crying, induced by the many dressing changes needed to obtain haemostasis, resulted in raised intrapulmonary pressure sufficient to rupture a weak site and cause pneumothorax. Although the child was managed successfully, this required a further hospital stay of 19 days.

## Bleeding

Bleeding remains the commonest complication encountered during and after circumcision. Because varying criteria have been used when recording this complication and because of inadequate documentation, the reported incidence ranges from [illegible] In the majority of cases bleeding [illegible] to achieve haemostasis is gentle pressure on the area. Excessive bleeding may be due to [illegible] a bleeding disorder[24]. After 13 000 circumcisions reported in two large series, no patient required blood transfusion for bleeding[24,25]. In the event of a bleeding disorder, appropriate clotting factors may have to be administered[24]. The authors are not aware of any reported cases of exsanguination following circumcision.

In some instances the application of pressure alone is insufficient to control local haemorrhage and other methods of haemostasis must be employed. In the UK the commonest aid to haemostasis is electrosurgical diathermy for coagulating vessels. While in the majority of situations the judicious use of this device is safe and effective, the potential for damage exists if it is employed overzealously. When used in monopolar form, an electrical current flows from the indifferent electrode (plate) to the active electrode (forceps) and the tissue surrounding the forceps is heated, resulting in coagulation. However, this coagulation process may spread proximally in small vessels (a phenomenon commonly observed in everyday practice) and the extent of vessel coagulation may be far greater than anticipated or intended. It is predominantly for this reason that the present authors use only *bipolar* diathermy during circumcision. Although there are probably many undocumented cases of minor diathermy burns and sloughing of the affected penile skin, more severe injuries such as glans and major penile skin necrosis have been reported[12,27]. At its most severe, the use of diathermy may result in total ablation of the penis. Gearhart and Rock[31] described four such cases in which damage was so severe that plastic surgical reconstruction was deemed impossible. In all cases the children were managed by gender reassignment and feminizing genitoplasty.

If simple application of pressure is unsuccessful, a type of circumferential bandage may be applied to aid haemostasis. This appears to be popular among the practitioners of religious circumcision in Jewish communities. It may cause a degree of urethral obstruction which, in severe cases, leads to urinary retention[36] and may thus predispose to urinary tract infection[37]. Horowitz *et al.*[38] described such an event in which an 18-day-old infant presented shocked, dehydrated and with a hugely distended abdomen 2 days after circumcision. The tip of the penis, which was still covered by a circular bandage, appeared red and necrotic. After the bandage was released the child voided a large volume of urine and the abdominal distension disappeared. The cause of systemic upset was an *Escherichia coli* urinary tract infection and subsequent septicaemia. Frand *et al.*[39] described an infant about whom the parents were concerned because of bluish discoloration of the legs 1 day after circumcision; a circular bandage was seen around the penis. After this was removed a large volume of urine was voided and the lower-limb cyanosis rapidly disappeared. It is presumed that the distended bladder compresssed the iliac veins and so impeded venous return from the legs. Acute urinary retention may also be caused by the devices sometimes used for circumcision; in one case where the Plastibell device (Abbott Laboratories, Queenborough, UK) was employed, rupture of the bladder was a consequence of acute urinary retention[40]. As well as compressing the urethra, the blood flow to the distal penis and glans may also be compromised by the tourniquet action of a circumferential dressing, which in severe cases may result in necrosis of the distal penis and glans[41].

Pharmacological agents may also be used to stop minor troublesome bleeding and in this respect the application of 1:100 000 adrenaline solution is not uncommon. Although there is a slight danger from systemic absorption, at this low concentration complications are unlikely. If a more concentrated solution is used, however, there is greater systemic absorption with its attendant problems. Mor *et al.*[42] described four such cases in which a sponge-soaked solution of 1:1000 adrenaline had been applied to the circumcision wound and left in place for a few hours. All the children developed tachycardia and heart failure but were successfully managed with digoxin and diuretics. Denton *et al.*[43] reported a similar case of a neonate in whom 0·1 ml of 1:1000 adrenaline was sprayed on to the

bleeding area of the frenulum after circumcision. The patient developed tachycardia, acrocyanosis and local pallor of the penis. After subcutaneous injection of phentolamine (an α-adrenergic receptor antagonist) at the base, shaft and corona of the penis, all penile pallor disappeared and the systemic signs abated.

As an alternative to diathermy, obvious bleeding vessels may be ligated with a fine suture. One of the commonest sites for persistent bleeding is at the frenulum, and in this area it is not uncommon to insert a haemostatic suture. However, because of the close proximity of the underlying urethra, it is easy for such a haemostatic stitch to be placed in the urethra itself. The result is the development of a urinary fistula[44,45]. Avoidance of this complication therefore depends on meticulous technique when suturing around the frenulum and in taking superficial tissue only in the stitch.

## Sepsis

Infection occurs after circumcision in up to 10 per cent of patients[3,15]. In the majority of cases this is usually mild and manifested by local inflammatory changes, but occasionally there is ulceration and suppuration. Most infections are of little consequence and settle with local treatment. Occasionally, however, sepsis may have much more alarming consequences and may even cause death[46–48].

The perineal skin is heavily colonized by both normal skin saprophytes and by bowel flora, and it is surprising that significant septic complications do not occur more frequently. Woodside[49,50] reported a case of necrotizing fasciitis of the perineum after Plastibell circumcision in a neonate. The child was septicaemic and there was also bacterial contamination of the cerebrospinal fluid. Extensive surgical debridement of the perineum with multiple fasciotomy was necessary and parenteral antibiotics were administered. *Staphylococcus aureus*, *S. epidermidis*, diphtheroids, α-haemolytic streptococcus and *Clostridium perfringens* were cultured from the excised perineal and penile skin. The child survived and had a satisfactory cosmetic and functional result some years later.

Gangrene of the penis has also been reported following circumcision[51] and the scope of microbial contamination of the perineal skin can be further appreciated from the report of Sussman *et al.*[52] of two cases of Fournier's syndrome of the perineum and scrotum following the operation. Both patients survived after adequate antibiotic management, although extensive surgical debridement was necessary in one child. Annunziato and Goldblum[53] presented three cases of staphylococcal scalded skin syndrome all of which occurred after circumcision and, similarly, cases of impetigo have been documented[54]. In 1935, Gosden[47] reported a series of 23 boys from Cyprus circumcised by an unqualified practitioner in 13 of whom tetanus developed; five died. Diphtheria may develop in a circumcision wound[55] and infection with *Mycobacterium tuberculosis* has been documented[18]. The circumcision site has been observed to be the portal of entry in many other cases of sepsis, and Cleary and Kohl[56] reported a fatal case of septicaemia with group B β-haemolytic streptococcus in a 6-week-old child. Kirkpatrick and Eitzman[57] highlighted the significance and occurrence of septicaemia following circumcision with the Plastibell device. Metastatic infection from the circumcision site has been reported as a cause of neonatal meningitis in five children[58,59], three of whom were treated successfully with no long-term sequelae. However, one child subsequently developed cerebral palsy and one died. Osteomyelitis of the femur[25] and a fatal case of staphylococcal bronchopneumonia[60] have also been reported following circumcision. Recently, Crowley and Kesner[48] reported a 9 per cent mortality rate in a series of 45 consecutive admissions for septic complications following ritual circumcision in young adults. Septic embolization and polyarthritis were among the documented complications of septic circumcision in this series. Despite its apparently low incidence, sepsis following circumcision has the potential to cause significant morbidity and in some cases death.

## Fistula

Urethrocutaneous fistula following circumcision may occur for a variety of reasons but, fortunately, the reported incidence of this complication is low. Perhaps the commonest cause is a poorly placed suture at the frenulum in an attempt to obtain haemostasis[44,45]. This results in strangulation and necrosis of part of the urethral wall, with resultant subglandular fistulation not dissimilar to glandular hypospadias. Fistulation may also occur as a result of sepsis[61] or unrecognized rare penile anomaly, such as megalourethra[62]. However, many other fistulas arise from using the Plastibell device or Gomco clamp[12,44]. Although the mechanism of injury is not clear it is probable that urethral injury results from crushing by the device. Most of these fistulas open on to the dorsum of the penis (but they may also open to the ventral surface), an anatomical arrangement not dissimilar to that seen in epispadias. Such a case was reported following surgical bivalving of the glans[33]. Although there are many approaches to the management of such a urethral fistula[63], appraisal of the techniques employed is beyond the scope of this review.

## Meatal stenosis

Meatal stenosis is generally a direct consequence of circumcision that is seldom encountered in uncircumcised men; meatal calibre is known to be greater in uncircumcised individuals. The incidence of meatal ulceration following circumcision is from 8 to 20 per cent[14,46,64]. The aetiology is thought to be irritation of the external urethral meatus by ammoniacal substances present in wet sodden nappies. Such irritation is unlikely in the presence of a normal prepuce, which serves to protect the glans from these irritant substances[46]. In a prospective study of 140 consecutive neonatal circumcisions, Mackenzie[64] found a 20 per cent incidence of meatal ulceration within the first 2–3 weeks after circumcision. It is thought that meatal ulceration after circumcision is the initiating event in a vicious cycle of stenosis and ulceration, followed by more stenosis[64]. Meatal stenosis following circumcision has been advanced as a cause of recurrent pyelonephritis and obstructive uropathy, for which meatotomy is curative[64,65].

## Miscellaneous complications

The glandular epithelium may be denuded by a less than gentle technique when separating the preputial adhesions and this may be exacerbated if the glans is held firmly by a gauze swab. The glans may then be more prone to local sepsis with the resulting formation of a scab. Fortunately, most settle spontaneously with attention to hygiene. A skin bridge may develop between the glans and the penile shaft. This may tether the erect penis so producing pain and deformity. The aetiology of this condition remains unknown, although injury to the glans at the time of circumcision or incomplete separation of the inner prepucial skin have been advanced as possible factors[12,66]. Inclusion cysts following circumcision have been described. That reported by Shulman *et al.*[25] was found histologically to be an epidermal cyst. It is possible that cysts also arise as a result of peroperative implantation of smegma. The use of silica talc on surgical gloves has been associated with the formation of granulomas and such a lesion was described in a circumcision wound 15 years after the original surgical procedure[67]. Although penile lymphoedema following circumcision has been reported, there is a paucity of information regarding the aetiology and management of such a problem and accounts in the literature are anecdotal[11,25]. The degree of penile oedema may be greater with the Plastibell device[68]. Impotence has been observed following circumcision[69]. Palmer and Link[70] described two cases, both of which were associated with

injection of 1 per cent lignocaine directly into the corpora and application of a rubber band at the base of the penis to act as a tourniquet. As 10–15 ml anaesthetic was used this perhaps resulted in a 50 per cent mixture of lignocaine and blood in direct contact with the vascular endothelium of the penis. It is postulated that this high concentration irreversibly damaged the endothelium of the corpora cavernosum with resulting impotence. Impotence followed partial amputation of the penis at circumcision, despite plastic surgical reconstruction, in a case reported by Hanash[71]. Hypospadias remains a contraindication to circumcision, as surgical reconstruction may require the use of all the available penile skin. However, circumcision in unrecognized hypospadias was performed in six children in one series and, in the same series, although hypospadias was recognized in two children, circumcision was performed anyway[24].

## Carcinoma

Of 1103 patients with carcinoma of the penis reviewed by Wolbarst[72], none had been circumcised. It was therefore concluded that squamous carcinoma of the penis only ever occurs in uncircumcised men and that the circumcised state is protective against its development. However, squamous cell carcinoma of the circumcised penis has since been reported[73,74] and so the original contention of a protective effect of circumcision is not convincing. Indeed, when one compares the incidence of carcinoma of the penis in the USA (0·2·1 per 100000) where most men have been circumcised at birth, with that in Denmark (1·1 per 100000) and Japan (0·3 per 100000), where circumcision is rarely performed, the original contention seems doubtful[5,75]. It is likely that several factors other than circumcision are implicated in the genesis of carcinoma of the penis.

Carcinoma of the penis following circumcision appears to have a different natural history from cancer in uncircumcised men. Whereas penile cancer in the uncircumcised tends to arise on the glans or prepuce, after circumcision the tumour is likely to develop in the surgical scar. Such tumours occur mostly on the penile shaft and tend to spread locally with distant metastasis as an infrequent or late occurrence[76]. Surgical excision is the treatment of choice, as neither radiotherapy nor chemotherapy appears to be effective[77]. Nearly all of these cases have been reported from Saudi Arabia, where there existed a radical form of circumcision that was practised by the tribes in the southern regions. The circumcision included excision of the skin in the suprapubic region with a longitudinal incision extending between the anterior superior iliac spines[78]. This practice is now prohibited.

## Psychological complications

According to Freudian theory, by the fourth or fifth year of life the genital concentration of all sexual excitement is achieved and the boy's interest in the genitals attains a dominant significance, the phallic stage. Anna Freud[79] wrote:

> 'any surgical interference with the child's body may serve as a focal point for the activation, reactivation, grouping and rationalisation of ideas of being attacked, overwhelmed and (or) castrated'.

For a child at the phallic stage this fear that something might happen to his prized organ is called 'castration anxiety'. According to the psychoanalytical literature, operations performed on the penis, such as circumcision, may arouse such castration fears. In a study on circumcision and the problems of bisexuality, Nunberg[80] highlighted the point that injury to the penis may intimidate the child and impair his development to full virility. However, in the same paper he also proposed that circumcision may stimulate the masculine striving of the child by encouraging identification with the father. After a detailed prospective psychoanalytical study of 12 boys aged 4–7 years undergoing circumcision in Turkey, Cansever[81] intelligence quotient and that body image perception showed a tendency to contract. She concluded that:

> 'circumcision is perceived by the child as an aggressive attack upon his body, which damaged, mutilated, and in some cases totally destroyed him. The feeling of "I am now castrated" seems to prevail in the psychic world of the child. As a result he feels inadequate, helpless and functions less efficiently'.

Such psychological sequelae are not confined to the young child. Circumcision performed in the neonatal period is associated with marked behavioural changes[82,83] that may last up to 24 h; supporting this observation is the finding of a rise in both serum cortisol and cortisone levels after neonatal circumcision[84]. Circumcision in the neonate has been noted to increase both respiration and heart rate and is associated with a significant fall in transcutaneous oxygen tension[85]. Allied to this is a change in sleep pattern with prolonged non-rapid eye movement sleep. This change has been interpreted as 'being consistent with a theory of conservation–withdrawal to stressful stimulation'[86].

Circumcision can cause dysmorphophobia, and Walter and Streimer[87] reported a case of genital self-mutilation in a non-psychotic patient who attempted to reconstruct the foreskin himself. Two groups of men seeking restoration of the foreskin have been identified. First is a group of Jewish men who sought to disguise their religious identity during times of political crisis[88]. Second is a group of homosexuals whose circumcised status is associated with unwanted masculinity and anger over having no choice over their circumcision[89]. Genital self-mutilation by attempted circumcision has been reported after paternal death in two patients, both of whom demonstrated features of acute psychosis[90]. Schizophrenia following elective circumcision has also been reported[91].

In societies in which circumcision is intricately linked to tradition and culture, the uncircumcised individual is likely to be an outcast. This prejudice may be great enough for uncircumcised men not only to be ostracized by their peers but even to be attacked and beaten for their lack of conformity. Such beatings in men refusing to be circumcised have occurred in the Xhosa tribe of South Africa and, in one instance, the attack was violent enough to result in the development of 'crush syndrome'[48].

## Sexual complications

Morgan[92] asserts that:

> 'penetration in the circumcised man has been compared to thrusting the foot into a sock held open at the top while, on the other hand, in the intact counterpart it has been likened to slipping the foot into a sock that has been previously rolled up'.

He also suggests that 'coitus without a foreskin is comparable to viewing a Renoir whilst colour blind'[93]. While it is impossible to reach an objective conclusion in this matter, some have risen to the challenge[94] and attempted to investigate the question. Although Harnes[95] concluded that 'the question remains unanswered' at the end of his study, the description of his methodology and findings makes for compulsive reading.

## Conclusion

Many medical practitioners regard circumcision as a relatively minor procedure and, as such, it is likely to be delegated to a junior surgeon. It has already been observed that complication rate is directly related to operator inexperience[3]. Delegation to a junior colleague should occur only after the surgeon in training has been fully instructed in the operative procedure. Heightened awareness of the scope and potential for complications will of itself result in a reduced complication rate.

Despite the recommendation of the British Medical Association that circumcision should be performed only for medical reasons, controversy still exists over whether too many

procedures are being carried out. It is hoped that a greater awareness of the incidence and scope of associated complications will encourage a more carefully considered decision on whether or not to circumcise.


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CASE STUDY A

CASE STUDY B

APPENDIX

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Paper accepted 18 May 1993

Since the above study dispels the myth that circumcision is a harmless procedure (". . . the literature abounds with reports of morbidity and even death as a result of circumcision") we include a full copy of the paper—"Complications of Circumcision" —with this report *(see preceding pages)*.

**Estimated Worldwide Incidence of Male Circumcision Complications**

Tim Hammond of NOHARMM very recently compiled figures—using Williams' and Kapila's "2-10 per cent" complication rate to come up with an estimate of the worldwide incidence of male circumcision complications. Using world population figures from 1994 he came up with the following "conservative" figures:[15]

| | | |
|---|---|---|
| A—World Population (1994): | | 5,661,525,000 (5.6 billion) |
| B—Male Population (50% of A): | | 2,830,762,500 (2.8 billion) |
| C—Circumcised Male Population: (20%* of B) | | 566,152,500 (566 million) |
| D—Number of Complications at rate of: | 10% | 56,615,250 (56.6 million) |
| | 2% | 11,323,050 (11.3 million) |
| | 1% | 5,661,525 (5.6 million) |

*The 20% figure is extrapolated from researcher Edward Wallerstein's deduction that: *"About 80% of the world's population do not practice circumcision, nor have they ever done so."*[16]

**Therefore, using the complication estimate from Williams and Kapila, somewhere between 11.3 million and 56.6 million men have suffered or are suffering from damage to the penis as a direct result of being circumcised.**

Hammond writes: "Cultural, religious, emotional, psychological and gender-based factors inhibit the vast majority of mutilated males from speaking out about this harm."[17]

In addition to the above, all circumcisions cause damage to the penis by destroying the frenulum, removing potentially erogenous tissue ***(see Appendix V)*** and by forcing the glans to accomodate its unnatural exposure by keratinizing, thereby becoming dry and tough. The nerve endings in the glans, which in the intact penis are just beneath the surface of the mucous membrane, are now buried by successive layers of keratinization. This results in a radical desensitizing of the glans, compared to what was designed by nature.[18]

## APPENDIX V

"Depending on the amount of skin cut off, circumcision robs a male of as much as 80 percent or more of his penile skin . . . Careful anatomical investigations have shown that circumcision cuts off more than 3 feet of veins, arteries, and capillaries; 240 feet of nerves and more than 20,000 nerve endings."[19]

"Meissner's corpuscles of the prepuce may be compared with similar nerve-ending in the finger-tips and lips, which respond in a fraction of a second to contact with light objects . . .The prepuce provides a large and important platform for several nerves and nerve endings. The innervation of the outer skin of the prepuce is impressive; its sensitivity to light touch and pain are similar to that of the skin of the penis as a whole. The glans, by contrast, is insensitive to light touch, heat, cold and, as far as the authors are aware, to pin-prick. Le Gros Clark noted that the glans penis is one of the few areas on the body that enjoys nothing beyond primitive sensory modalities."[20]

**In the light of current research, it appears that excision of the prepuce removes the most sensitive, erogenous tissue of the male organ.**

# APPENDIX VI

The following examples of social ostracism illustrate the kind of abuse that can be suffered by the uncircumcised male child or by those boys who "cry out" during the pain of the ritual:

## Maasai

"In the case of a boy who has cried out during the operation, the spectators will declare him a coward and will not partake of the meat, milk, or honey beer provided by his parents for the occasion. A ceremony that has taken a month or more to prepare will be useless. The youth is termed one who has 'kicked the knife,' and along with his family he will be disgraced. His father and mother will be spat upon for having raised a coward. The family' cattle within the kraal will be beaten until they stampede and break through the fence. The boy will also receive a thorough beating. The food he eats will be spat upon and he must eat all of it . . ."[22]

## Xhosa

". . . in Xhosa tradition an uncircumcised male cannot inherit his father's possessions, nor can he establish a family. He cannot officiate in ritual ceremonies. In fact there is no such thing as an 'uncircumcised man' in Xhosa society. A Xhosa who is not circumcised is described quite simply as a boy, an *inja* (dog), and an *inqambi* (unclean thing) . . . So uncompromising are the Xhosa people on this that no Xhosa woman would knowingly and willingly marry an uncircumcised Xhosa male."[23]

"Obligatory circumcision in a sterile operating theatre, replacing the Izichwe with a trained doctor or substituting commercial dressings and medicines for the traditional leaves and sheep-skin, would render the Umkhwetha meaningless . . . any youth who undergoes hospital circumcision by request will be a social outcast."[24]

## Walbari of Aboriginal Australia

"The rite of circumcision and its attendant ceremonies firmly and unequivocally establish a youth's status in Walbari society. Should he fail to pass through these rites he may not enter into his father's lodge, he may not participate in religious ceremonies, he cannot acquire a marriage line, he cannot legitimately obtain a wife, in short, he cannot become a social person."[25]

## Biblical Judaism

The covenant between Jehovah and Abraham which is the foundation of the current Jewish religious practice of circumcision carried with it a penalty for non-performance of the ritual:

"Every man child among you shall be circumcised. And ye shall circumcise the flesh of your foreskin . . . he that is eight days old shall be circumcised among you . . ."[26]

"And the uncircumcised man child whose flesh of his foreskin is not circumcised, that soul shall be cut off from his people; he hath broken my covenant."[27]

If one compares other scriptures with the same phrase "cut off from his people" one understands there is a strong possibility that this penalty actually meant "death".[28]

# Current Position Statements of Medical Societies in English-Speaking Countries on Routine Infant Male Circumcision

**1996** Fetus and Newborn Committee, Canadian Paediatric Society: *Neonatal Circumcision Revisited*—"Circumcision of newborns should not be routinely performed." [*Canadian Medical Association Journal* March 15, 1996, Vol. 154, No. 6: 769.]

**1996** Australasian Association of Paediatric Surgeons: *Guidelines for Circumcision*— "We do not support the removal of a normal part of the body, unless there are definite indications to justify the complication and risks which may arise. In particular, we are opposed to male children being subjected to a procedure, which had they been old enough to consider the advantages and disadvantages, may well have opted to reject the operation and retain their prepuce." [Hersion, Queensland. April 1996]

**1996** Australian College of Paediatrics: *Position Statement on Routine Circumcision of Normal Male Infants and Boys*— "The Australasian Association of Paediatric Surgeons has informed the College that 'Neonatal male circumcision has no medical indication. It is a traumatic procedure performed without anaesthesia to remove a normal functional and protective prepuce.'" [Parkville, Vic. 27 May 1996]

**1996** British Medical Association Guidelines: *Circumcision of Male Infants: Guidance for Doctors*— "To circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate." [Medical Ethics Department. London. 1996]

**1996** Australian Medical Association: "The Australian College of Paediatrics should continue to discourage the practice of circumcision in newborns." [*Australian Medicine* 20 January 1997, page 5.]

# APPENDIX VIII

AMERICAN CANCER SOCIETY
NATIONAL HOME OFFICE

February 16, 1996

Dr. Peter Rappo
Committee on Practice & Ambulatory Medicine
American Academy of Pediatrics
141 Northwest Point Boulevard
P. O. Box 927
Elk Grove Village, IL 60009-0927

Dear Dr. Rappo:

As representatives of the American Cancer Society, we would like to discourage the American Academy of Pediatrics from promoting routine circumcision as preventative measure for penile or cervical cancer. The American Cancer Society does not consider routine circumcision to be a valid or effective measure to prevent such cancers.

Research suggesting a pattern in the circumcision status of partners of women with cervical cancer is methodologically flawed, outdated and has not been taken seriously in the medical community for decades.

Likewise, research claiming a relationship between circumcision and penile cancer is inconclusive. Penile Caner is an extremely rare condition effecting one in 200,000 men in the United States. Penile cancer rates in countries which do not practice circumcision are lower than those found in the United States. Fatalities caused by circumcision accidents may approximate the mortality rate from penile cancer.

Portraying routine circumcision as an effective means of prevention distracts the public from the task of avoiding the behaviors proven to contribute to penile and cervical cancer: especially cigarette smoking and unprotected sexual relations with multiple partners. Perpetuating the mistaken belief that circumcision prevents cancer is inappropriate.

Sincerely,

Hugh Shingleton, M.D.
National Vice President
Detection & Treatment

Clark W. Heath, Jr., M.D.
Vice President
Epidemiology & Surveillance Research

1599 CLIFTON ROAD, N.E., ATLANTA GEORGIA 30329 404-320-3333

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# Comments from Humanitarians

"Circumcision is a brutal ritual rooted in superstition and should be abandoned . . ."
—Ashley Montagu, anthropologist and Humanist of the Year, 1995

"We use the word 'circumcision,' but this is a euphemism. What we are really talking about for females as well as males is culturally and religiously sanctioned sexual mutilation and child abuse."
—Miriam Pollack, Jewish educator and author of *Redefining the Sacred*

"The forced amputation of a healthy part of the genitals of an unconsenting infant or child, whether in the name of medicine, religion, or social custom is a human rights violation."
—Nurses for the Rights of the Child, Santa Fe, New Mexico

"Removed from both ritual and medical grounds of justification, circumcision emerges as nothing more nor less than a classic instance of genital mutilation practiced on helpless children. As such, it should not be countenanced."
—Lawrence A. Hoffman, author of *Covenant of Blood: Circumcision and Gender in Rabbinic Judaism*

". . . there is no valid justification of the distinction made between male and female circumcision."
—Sami A. Aldeeb Abu-Sahlieh, Staff Legal Advisor at the Swiss Institute of Comparative Law

"I now think that a full-scale campaign should be waged to eliminate circumcision, whether of the male or the female."
—Lester A. Kirkendall, Ph.D., Humanist of the Year, 1983

# A Boy Without a Penis

## The experts had it all wrong, says the beleaguered survivor of a landmark 1960s sex-change operation

By CHRISTINE GORMAN

HE WAS ONE OF A SET OF INFANT TWIN boys when, in 1963, his penis was damaged beyond repair by a circumcision that went awry. After seeking expert advice at Johns Hopkins Medical School, the parents decided that the child's best shot at a normal life was as an anatomically correct woman. The baby was castrated, and surgeons fashioned a kind of vagina out of the remaining tissue. When "she" grew older, hormone treatments would complete the transformation from boy to girl.

The case became a landmark in the annals of sex research, living proof of the prevailing theory of the 1960s and early 1970s that sexual identity exists in a kind of continuum and that nurture is more important than nature in determining gender roles. Babies are born gender neutral, the experts said. Catch them early enough, and you can make them anything you want. Widely cited in medical and social-science textbooks, the baby's transformation helped pediatricians confidently advise other parents facing similar circumstances to rear their wounded boys as girls.

JORDIN ISIP FOR TIME

What these doctors and parents didn't know was that the celebrated sex-change success story was, in fact, a total failure. In a follow-up study published last week in the *Archives of Pediatric and Adolescent Medicine*, Milton Diamond, a professor of anatomy and reproductive biology at the University of Hawaii, and Dr. Keith Sigmundson, a psychiatrist with the Canadian Ministry of Health, report that the child, whom they called "Joan," never really adjusted to her assigned gender. In fact, Joan was surgically changed back to "John" in the late 1970s, and is now the happily married father of three adopted children.

Almost from the beginning, Diamond and Sigmundson write, Joan rebelled at her treatment. Even as a toddler, she felt different. When her mother clothed her in frilly dresses, she would try to rip them off. She preferred to play with boys and stereotypical boys' toys—in one memorable instance walking into a store to buy an umbrella and walking out with a toy machine gun. By second grade, she had come to suspect she would fit in better as a boy. But her doctors insisted that these feelings were perfectly normal, that she was just a tomboy. "I thought I was a freak or something," John told Diamond and Sigmundson in interviews conducted in 1994 and 1995.

Although the other kids didn't know about Joan's surgical history, they teased her about her tomboyish looks and behavior. Public bathrooms proved to be a source of particular discomfort. Joan often insisted on urinating standing up, which usually made a mess. In junior high school, she stood so often in the stalls of the girls' rest room that the girls finally refused to let her in anymore, forcing her to use the boys' room instead.

By this time, Joan was pretty sure she was a boy. But no matter what she told her doctors and psychiatrists, they kept pressing her to act more feminine. Eventually, she gave up trying to convince them. "You can't argue with a bunch of doctors in white coats," John recalls. "You're just a little kid, and their minds are already made up. They didn't want to listen."

In 1977, when she was 14, Joan decided she had only two options: either commit suicide or live her life as a male. Finally, in a tearful confrontation, her father told her the true story of her birth and sex change. "All of a sudden everything clicked," John remembers. "For the first time things made sense, and I understood who and what I was." With the support of a new set of doctors, Joan underwent a pair of operations to reconstruct a penis—albeit a diminutive one without the sensitivity of a normal sex organ.

Following this second set of sex-change procedures, John's new doctors advised the family to move to a new town and another school and start over. This time, however, John's parents rejected the expert advice. People would find out anyway, they reasoned. It was better to stay put and be open about what had happened. Their strategy seems to have worked. After a brief transition, John was accepted by his peers in a way that Joan never was. Once, when John first began dating, he confessed to a would-be girlfriend that he was insecure about his penis, and she started telling tales in school about his condition. But Joan's old schoolmates stuck loyally by John, refusing to be drawn into the girl's malicious gossip.

At its worst, this story could be read as a lesson in scientific hubris. At its best, it's a story about the courage of one boy who claimed the right to determine his own identity.

Unfortunately, no follow-up study reporting that John had rejected his initial sex change was ever published. As a result, say Diamond and Sigmundson, dozens of other boys may have been needlessly castrated. In defense of the original team, Johns Hopkins says it wasn't able to conduct a follow-up because the family stopped coming to see its doctors.

Diamond and Sigmundson suspect that most boys-made-girls will, like John, reject their female identity by the time they reach puberty. Other experts are not so sure. "We don't have the answers," says Dr. William Reiner, a surgeon and psychiatrist at Johns Hopkins (who was not involved in the original case). "Let's listen to these kids. They eventually are going to give us the answer." —*Reported by Dick Thompson/Washington*

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# Ritual Circumcision (Umkhwetha) amongst the Xhosa of the Ciskei

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Summary—The Umkhwetha is an ancient custom of ritual circumcision still practised by the Xhosa people of Southern Africa. In 45 consecutive youths who required hospital admission the mortality rate was 9%. The complications seen over the years are reviewed and their management discussed.

No self-respecting Xhosa girl would marry a Xhosa male unless he had submitted to the Umkhwetha (*um.Kwe-ta*), the Xhosa circumcision ritual for which "boys" are expected to present themselves at between 18 and 22 years of age, although some delay the procedure until later.

The Xhosa people inhabit, in the main, the Ciskei and Transkei areas of Southern Africa. Exact numbers in the Ciskei are currently unknown. The last census was in 1980, when the total population was 630,353 with 178,774 resident in Mdantsane, the town in which this hospital is situated (Preliminary census, 1980).

## Patients and Methods

The Umkhwetha takes place twice a year in July and December. In ancient times it was said to have lasted several months. The rite is centred about a specially constructed hut of wattle staves and thatched grass. The circumcision is performed some distance from the hut by the Ingcitsi (surgeon). The boy lies motionless and silent. The Ingcitsi "gloves" the prepuce over his index finger, stretching it with thumb and middle finger. The tissue is rapidly excised with a sharp knife. Residual inner layer tissue is folded back over the distal shaft of the penis. The Izichwe (teacher) then applies specially gathered leaves around the penile shaft. The harmorrhage is staunched by tightly binding the organ with a strip of sheep skin leather. The penis is held obliquely erect by tying the stalks of the leaves to a bark waistband, using another strip of leather.

The would-be man then has his face and body painted white, using a paste made from ground local stone. On his head he wears a garland of mealie leaves. His clothing consists of a blanket only and he carries a white peeled stick. The Izichwe dresses the wound twice daily in the hut and also instructs the initiate in the ways of manhood. The teaching programme continues for about a month. Finally, the boys are taken to a fast-flowing stream where the paint is washed away. They return to the hut naked, where they are smeared with butter, given a new blanket and presented with a black unpeeled stick. After a final talk by a respected elder or relative, the boy becomes a man.

## Results

During the December–January period of the 1988/89 Umkhwetha, 45 consecutive young males with the diagnosis "septic circumcision" were admitted to the urological department at this hospital. This figure has no particular significance because the actual number of youths partaking in the Umkwetha and the true incidence of complications are unknown. Penile injury was defined in terms of 4 grades of severity (Table 1) and data on the patients are recorded in Table 2.

Two patients were admitted directly to the Intensive Care Unit (ICU); 1 had been severely beaten with a leather-whip (sjambokked) for refus-

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**Table 1** Penile Injury as a Result of Ritual Circumcision: Grades of Severity

| | |
|---|---|
| *Grade 1* | Skin loss at base of prepuce with or without laceration of glans or shaft |
| *Grade 2* | Marked loss of penile skin |
| *Grade 3* | Loss of the glans with or without partial shaft loss |
| *Grade 4* | Loss of the entire penis |

**Table 2** Details of 45 Consecutive Patients Admitted Following Ritual Circumcision

| | | | |
|---|---|---|---|
| *Age (years)* | | Mean | 21.5 (range 16-31) |
| *Mean time between circumcision and admission (days)* | | | 18 |
| *Dead on arrival (%)* | | 3/45 | (7) |
| *ICU admissions (%)* | | 2/45 | (4) |
| *Severity of penile trauma* | | | |
| *Grade* | *No. of patients* | *(%)* | |
| 1 | 14 | (33) | |
| 2 | 22 | (52) | |
| 3 | 4 | (10) | |
| 4 | 2 | (5) | |
| | | *No.* | *(%)* |
| Immediate surgery | | 2/42 | (5) |
| Suprapubic diversion | | 8/42 | (19) |
| Antibiotics | | 28/42 | (67) |
| Split-skin grafting | | 8/42 | (19) |
| Polyarthritis | | 2/42 | (5) |
| Mortality | | 4/45 | (9) |

ing to undergo daily penile dressings and had crush syndrome. The other had total necrosis of the penis (grade 4 lesion) with septicaemia and he died within 10 h of admission. The severity of penile injury could be graded in 42 patients; 22 (52%) had marked loss of penile skin (grade 2) and 6 (14%) had grades 3 or 4 lesions; 4 (10%) had lost their glans and in 2 patients (5%) the entire penis was necrotic. One of these died in ICU. The other youth remained quite well despite the presence of the dead organ. Understandably, he could not be convinced that ablation was necessary. Nature, however, took its course and discarded the dead appendage after 10 days. Two patients underwent immediate surgery; 1 required incision and drainage of an inguino-scrotal abscess and the other needed debridement of the glans penis.

Eight patients were diverted by suprapubic push-in catheter. The main indications were severe dysuria, difficulty with micturition as a result of penile tenderness or inability to avoid urine. No suprapubic catheter was required for longer than 4 days. A wide variety of antibiotics was administered by the admitting officers in 67% of the patients. Ampicillin and Ampiclox were the most favoured. Also used in variable combinations were cloxacillin, metronidazole, Bicillin, benzylpenicillin, tetracyclines and gentamicin. Our policy in the urological ward was to stop all antibiotics once the patient was apyrexial. A wide variety of organisms was cultured with no bacteria predominant. One-third of the patients did not receive antibiotic therapy. The mainstay of therapy was thrice-daily penile soakings in dilute Savlon solution followed by dressings with Betadine cream. This regimen succeeded in eliminating local sepsis in almost every case, allowing healing to occur in the vast majority.

Split-skin grafting was required in only 8 patients (19%). The penis showed an amazing propensity for spontaneous healing by advancing fronts of pink, new skin. These fronts originated from the proximal shaft skin edge, around the external urethral meatus and from residual islands of glans or shaft skin and were able to cover a startlingly wide area. Two patients had traumatic distal hypospadias and were advised to return for cosmetic surgery. The surviving patient with total penile loss was referred to a larger centre for reconstructive surgery.

Two patients were noted to have polyarthritis. One had painful effusions of both knees and had a grade 1 penile lesion. The other had inflammation of the left ankle and right wrist and had a grade 2 lesion. Aspiration yielded a sterile serous fluid in both cases. The signs and symptoms resolved spontaneously in each case within a month and we were informed by our orthopaedic collegues that this type of polyarthritis should be regarded as "reactive" or "sympathetic". There were 4 deaths and the mortality rate amongst the 45 youths was 9%.

## Discussion

The Umkhwetha is an ancient custom inherent in Xhosa society. It predates the advent of Western values in the African subcontinent by many centuries. It has always been accepted that those who did not survive were not destined to achieve manhood. With the advent of industrialisation in Southern Africa the fabric of tribal society has become increasingly fragile. Methods aimed at reducing the high complication rate should not

appear as a Western intrusion into this important custom. Obligatory circumcision in a sterile operating theatre, replacing the Izichwe with a trained doctor or substituting commercial dressings and medicines for the traditional leaves and sheep-skin, would render the Umkhwetha meaningless.

Apart from the management of complications, our role has been to bring the high morbidity and mortality to the attention of the regional Xhosa authority and advise how these could be reduced. We also circumcise boys and youths whenever a legitimate opportunity arises (such as a paraphimosis). Informed consent is essential but rarely is there a refusal. Parents are well aware of possible death and deformity associated with the Umkhwetha. Circumcision for genuine medical reasons is acceptable to the community, whereas any youth who undergoes hospital circumcision by request will be a social outcast.

The spectrum of complications observed over the years is outlined in Table 3. Septicaemia and/or dehydration are frequent causes of mortality. Normal fluid intake is discouraged as a further test of endurance and youths are frequently admitted severely dehydrated.

Rather than the act of circumcision itself, the chief cause of penile injury is the dressing when it is applied too tightly, for too long. The first effect is to compromise the blood supply of the penile skin. With tighter compression the deep dorsal arteries are also occluded and the glans may necrose (Figs 1 and 2). At worst all of the penile vasculature is occluded and the organ is lost.

The penile skin has a remarkable capacity for regeneration, but adjunctive surgical procedures are usually required for excessive skin loss and these include split-skin grafting and mobilising the

**Table 3** Complications of Ritual Circumcision

| |
|---|
| Death |
| Dehydration |
| Penile injury |
| Skin loss |
| Amputation |
| Fistula |
| Traumatic hypospadias |
| Traumatic epispadias |
| Infection |
| Localised |
| Regional abscess |
| Necrotising fasciitis |
| Septicaemia |
| Septic embolisation |
| Tetanus |
| Gangrene |
| Hepatitis B |
| AIDS |
| Polyarthritis |
| Urinary retention |
| Healing problems |
| Phimosis (after incomplete circumcision) |
| Meatal stenosis |
| Chordee |
| Severe beatings |
| Crush injury |
| Psychological disturbance |

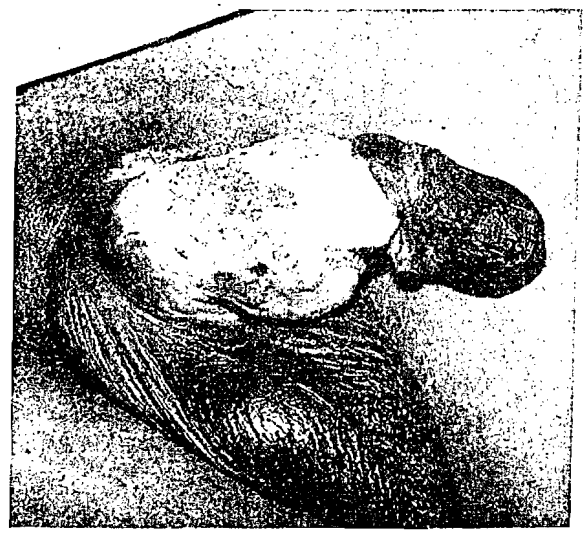

**Fig. 1** Septic ritual circumcision with marked loss of shaft skin. The glans is necrotic and about to slough.

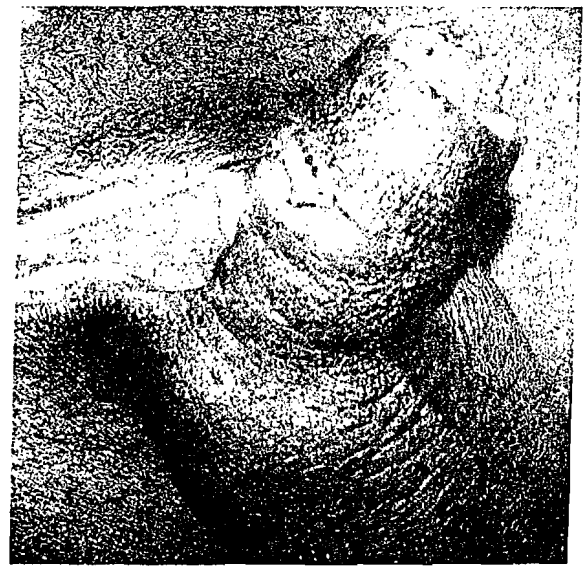

**Fig. 2** Another patient with loss of the glans penis. An inguinoscrotal abscess has been drained.

proximal shaft edge to provide distal cover as a sleeve. Occasionally we are faced with a situation of total skin and marked tissue loss that includes most of the pendulous urethra with a fistula at the peno-scrotal junction. For this we have used a technique termed "scrotal gloving". The denuded penile remnant is buried in the scrotum and the neo-glans brought out through a separate incision. The new glans is covered with split skin in an attempt to preserve sensitivity. The urethral fistula is converted into a first-stage urethroplasty by suturing the scrotal skin to the urethral edges. The previous site of emergence of the penile shaft is closed and the scrotum drained. Later, releasing incisions free the newly covered penis from the scrotum and standard hypospadias techniques are employed in an attempt to advance the new meatus. Three of 4 patients who underwent scrotal gloving stated that they had normal sensation, erections and ejaculation, but all had difficulty with penetration because of lack of penile length. The remaining patient had neither sensation nor erectile activity.

All patients had penile sepsis on admission. Our mainstay of therapy was thrice-daily penile soakings in dilute Savlon solution followed by dressings with Betadine cream. This regimen succeeded in eliminating local sepsis in almost every case. Antibiotics were reserved for those with systemic illness and were not administered to apyrexial patients. Several patients were treated for manifestations of septic embolisation such as empyema and soft tissue abscesses. We have also seen cases of tetanus (1 fatal) and serum hepatitis. All patients are now routinely given anti-tetanus toxoid on admission. As yet the youths are not routinely tested for AIDS, but it is a distinct possibility.

A common occurrence is incomplete circumcision. The penis is lacerated and there is severe posthitis and often phimosis. Once sepsis resolves we complete what the Ingcitisi originally set out to do. Meatoplasty may be required for stenoses that develop after urethral trauma or urethroplasty. Skin release or tethering procedures may be required for penile curvature after healing. Discipline in the bush is tough and beatings with a leather-whip (sjambok) are common. We have seen patients with crush syndrome and in renal failure as a consequence. One mildly retarded patient underwent circumcision but refused daily dressings. The severity of his beating can be gauged by the fact that he required both dialysis and ventilatory support for 3 weeks.

Circumcision in the adult may precipitate psychotic delusional behaviour (Ball, 1974; Flaherty, 1980). This is particularly likely when the procedure takes place as part of the Umkhwetha. When penile deformity results, the psychological scars will run deep.

## Acknowledgement

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# after circumcision

- 4 JUL 1997

By Ephraim Mackina

EAST LONDON — A teenager has died as a result of complications after undergoing ritual circumcision at an initiation school in Mdantsane.

Zola Tshoni, 19, a Std 9 pupil at Sikhulule High School in Mdantsane, died of dehydration during his third week at the initiation school.

The school principal, Mr Joe Bodoza, who described the teenager as bright and popular, said Zola had complained of knee and chest pains on Saturday.

"His parents took him to Cecilia Makiwane Hospital where he was treated and then returned to the bush the same day. Tribal

"On Monday, when Zola could not take any food, his parents hired a car to take him back to the hospital, but unfortunately he died on the way," he said.

Speaking on behalf of the boy's parents, Mr Bodoza attributed Zola's death to lack of both preparation and supervision during the initiation process.

"Whereas we know that circumcision is there to stay as it is part of our tradition, people need to understand that we are now living in a changing world where tradition has to keep pace with change.

"This is why certain staff in various clinics have been charged with the responsibility of examining initiates before they go through their course.

"Also, there is a need to ensure that only qualified staff are vested with the responsibility of looking after these initiates," he said.

So far this winter season, two other initiates have been admitted to Cecilia Makiwane Hospital, where they are being treated for infections, but no other circumcision-related deaths have been reported in the area, a senior medical superintendent at the hospital said.

Zola's funeral will take place at the Assemblies of God Church in NU2, Mdantsane, tomorrow.

By Mkhululi Titi

QUEENSTOWN — One of the two Xhosa circumcision initiates who were transferred from Cala to Frere Hospital in East London in December died this week.

This brought the number of deaths among initiates since the beginning of the circumcision period to three.

A Cala Hospital spokesman, Mr Mandla Zayedwa, said 35 initiates were being treated there. Tribal

Some were recovering while the wounds of others were still septic.

Several initiates admitted at Cala Hospital had been transferred to other hospitals such as Frere and Umtata General after their condition worsened, Mr Zayedwa said.

He said three other initiates were still being treated at Frere Hospital.

Some of the problems that have affected initiates in the area included dehydration, as an initiate is not allowed to drink water for seven days. 1997 -01- 0 8

Mr Zayedwa said some parents had to be blamed for the death of the initiates as they had refused to allow them to be treated in hospital.

As a result, the three who were transferred to Frere Hospital were so serious that they were found unconscious.

There were eight initiates at Hewu Hospital in Whittlesea who were all reported to be in a satisfactory condition, a hospital spokesperson, Mrs Nompucuko Mgole, said.

A meeting to discuss the problems faced by initiates with the communities would be held next Thursday at the magistrate's offices to encourage them to co-operate with hospitals to prevent loss of life, Mr Zayedwa said.

## Initiate, 22, found dead

Tribal

QUEENSTOWN — A 22-year-old man who complained of being thirsty and of dizziness after his circumcision last weekend was found dead in Burgersdorp at the weekend, police said yesterday. Kayaletha Meva had undergone a traditional circumcision on December 13 and during the weekend complained that he was not feeling well. He was found dead by a man taking care of him at a circumcision school. — DDR

# Two Xhosa initiates die, 59 in hospital

Tribal

1997 -01- 03

Daily Dispatch Reporters

QUEENSTOWN — At least 59 Xhosa initiates have been admitted to various Eastern Cape hospitals during the long weekend as a result of circumcision-related problems while two more were transferred to the Frere Hospital in East London.

Two died at Cala Hospital.

Sister Nomvo Sikhunyane at Cala Hospital said initiates died at the hospital gates at the weekend last week before they were even admitted for treatment. To date, 22 initiates have been treated there.

A hospital spokesperson at Cofimvaba Hospital said 17 initiates have been admitted there and one was in a critical condition. All the initiates were admitted with severe bleeding. The rest were in a stable condition.

A hospital spokesperson at Hewu Hospital in Whittlesea, Sister Nothemba Zono, said 13 initiates have been admitted there and were all in a satisfactory condition and would be released soon.

There are seven initiates at Frontier Hospital here and all were said to be in a satisfactory condition yesterday.

● An initiate was transferred from the Stutterheim to Frere Hospital in East London in a "very bad" condition, a hospital spokesman said yesterday.

Mr Walter Makhonjwa said the initiate was admitted to Frere hospital on New Year's Eve after his condition started to deteriorated.

"Even though the initiate is in a very bad state, I do not foresee his penis being amputated. We have treated initiates in worst conditions and most of them recovered," Mr Makhonjwa said.

He said three of the nine initiates admitted to the hospital last month had recovered and were sent back to their various homes. The other six initiates were reported in a stable condition and were expected to be sent home soon.

A spokesman for Stutterheim hospital, Dr Pieter Brink, said there was only one initiate at the hospital and was in a stable condition.

# 3 initiates die – charges urged

- 5 JUL 1997

By Phakamisa Ngani

UMTATA — An advocate who also heads the Bhala tribe in Flagstaff has called for police action against a traditional surgeon and his monitors following the death of three "abakhwetha" circumcision initiates and surgical complications to 23 others in Eastern Pondoland last week. Tribal

Chief Mwelo Nonkonyana said yesterday he had urged police to open murder dockets against the surgeon, and against four other men who had served as "abakhwetha" monitors in the botched circumcision processes.

He named the surgeon and four monitors — known as "amakhankatha".

He also asked police to open serious assault dockets against the men responsible for the circumcision school "atrocities" because some of the initiates had to have their penises amputated.

Only one of the 27 initiates escaped death or serious surgical complications.

Chief Nonkonyana said postmortem results suggested the three young victims — Qekeza Mbaligontsi, Lubabalo Gontsana and Sandile Bili — had severe internal bleeding.

After the death of the first victim, Mbaligontsi, there was a public outcry against operations at the man's circumcision lodge.

The men in charge of the school, however, defied protests and insisted on the establishment of two other circumcision lodges elsewhere, Chief Nonkonyana claimed.

The actions of those responsible for the deaths of the three young initiates called for condemnation "in the strongest possible terms", he said.

"I have also instructed my councillors to summon the parents of the affected initiates to our tribal court and charge them with breaking the custom of the Bhala tribe.

"The respondents must explain why they failed to obtain relevant authority before conducting the circumcision school.

"They should also prepare themselves for the painful consequences of their actions," he said.

He had also directed his tribal subjects to demolish the circumcision school lodges in which the three initiates lost their lives.

He claimed that the lodges had been built without prior approval from his traditional authority.

An advocate attached to the Umtata High Court, Chief Nonkonyana is the Eastern Cape regional president of the Congress of Traditional Leaders in South Africa (Contralesa).

He is also chairman of the Bisho-based House of Traditional Leaders where members of the forum have expressed strong views about circumcision schools conducted without strict adherence to traditional Xhosa norms and customs.

# Surgeon held over death of initiates

KOKSTAD — Police yesterday arrested a traditional surgeon suspected of causing the deaths of five Xhosa circumcision initiates and injuring numerous others in the Lusikisiki district of the Eastern Cape, a spokesman said.

Captain Gugulethu Matha said a 37-year-old suspect was arrested on Monday night and was due to appear in court today.

Kokstad regional health director Chauke Tyekela said in a statement 62 initiates were admitted to St Elizabeth Hospital in Lusikisiki in the first two weeks of July.

Those who had died had suffered from severe infection, 11 had had their penises amputated and one had been transferred to Umtata Hospital with suspected brain complications. Eight initiates were still in hospital, he said.

A further 23 initiates were admitted to the Mary Theresa Hospital, in Mount Frere, and five to St Patrick's Hospital, in Bizana.

Capt Tyekela said the infections in initiates could be attributed to the death of one of the traditional surgeons in the district who had been most involved in the circumcision rituals. — Sapa

# 3 burn to death, 2 initiates die

**Daily Dispatch Reporter**

UMTATA — Three children were burnt to death at Embalisweni location near Libode yesterday and two Xhosa initiates died of sepsis, police said yesterday.

Thembela Mbangatha, 15, his brother Silindile, 6, and Madoda Mthimba, 4, were asleep when their house went up in flames early yesterday.

A police spokesman, Captain Monde Nqadini, said it was believed the fire resulted from a burning candle falling over.

The children's parents were not in the house at the time and neighbours struggled in vain to put the fire out.

● Capt Nqadini said two intitiates died after undergoing circumcision rituals earlier this month.

Thamsanqa Mpongwana, 18, of Ngangelizwe, died at the weekend and Zola Kasana, 18, died on Tuesday after complaining of dizziness.

Capt Nqadini said a third initiate was in a serious condition in Umtata General Hospital after suffering from dizziness and vomiting.

# 4 die after circumcision

**LUSIKISIKI — Four initiates have died after being circumcised and another 36 have been admitted to hospital here during the past week.**

**At least three of those in hospital have had their penises amputated.**

**The initiates come from 11 villages in the Lusikisiki and Flagstaff districts.**

**Health officials at St Elizabeth Hospital said the initiates were suffering from a number of complications, including septic wounds, dehydration, exposure and malnutrition. — DDC**

# Initiates: police open murder case

UMTATA — Police have opened five murder dockets in respect of five initiates who died during circumcision rituals in the Lusikisiki area last week, Inspector Mapelo Ngame said yesterday.

Authorities at St Elizabeth's Hospital confirmed last night that 53 other initiates were still receiving treatment. Three will have their penises amputated.

Insp Ngame said the initiates were between the ages of 18 and 21. According to information available to the police, each initiate paid R20 before the operation. Police said they were still searching for the man who performed the operations. — DDR

# Urban makhwetha dies after op goes wrong

By MTHOBELI MXOTWA

DUNCAN VILLAGE — A young Duncan Village man died at Frere Hospital after undergoing circumsicion last month.

A hospital spokesman, Mr Walter Makonjwa, said the young mkhwetha was admitted at the hospital after the circumcision operation went wrong.

The sick mkhwetha died over the weekend.

He said the initiate was from the Qwala family.

There were other sick bakhwethas at the hospital as well, he said.

Mr Makonjwa condemned the practice of using equipment which was not clean to circumcise initiates.

He said the blade and the bandages used should be sterile and clean.

An Mdantsane doctor last year suggested that whenever a mkhwetha became sick at the circumcision school he should immediately be taken to hospital.

He blamed the numerous deaths at the circumcision school on the prolonged wait in the bakhwetha house before the young man was taken to hospital.

He said some of the deaths could be prevented.

Duncan Village and Mdantsane have been hit by a spate of circumcision deaths in recent years during the circumcision seasons of December and June.

However, circumcision deaths were unheard of in rural areas where the operation was conducted by experienced and proven ingcibis. A young mkhwetha is looked after by considerate and experienced elderly men in rural areas whereas in the townships young men fresh from circumcision school themselves take care of abakhwethas.

# Student activist dies in rite

**EAST LONDON — A Butterworth Pan Africanist Student Organisation branch chairman, Mr Sabelo Somtha, 18, has died from circumcision complications.**

**He will be buried at his home at Qombolo, Keiskammahoek tomorrow.**

**The PAC spokesman in southern Transkei, Mr Waters Toboti, said after complications set in, Mr Sabelo was sent to Frere Hospital, where he died.**

**Sabelo was a standard 9 pupil at Langalethu junior secondary school in Butterworth. — DDR**

CASE STUDY C

# 99 youths treated for botched custom

QUEENSTOWN — Eastern Cape hospitals are still being inundated by Xhosa initiates with penises wounded in botched circumcision ceremonies which have resulted in several deaths during the Christmas holiday. Tribal

To date 99 initiates are receiving treatment at various hospitals in the region. 1997-01-09

Thirty five are patients at Cala Hospital where three have died from infection which set in after the traditional ceremony.

A traditional surgeon, often using the same blade on a string of initiates makes the cut to mark the Xhosa passage to manhood.

One initiate died at Cofimvaba after he was struck by lightning in his bush retreat grass hut in December.

The medical superintendent at Tafalofefe Hospital in Centani, Dr Collins Clark, said 15 initiates had been admitted to hospital but all were recovering.

Last year several initiates died at the hospital as a result of circumcision infections.

Health workers had since been visiting villagers to warn of the tradition's inherent dangers. Initiates responded well and were taking precautions.

There are 25 initiates at Butterworth Hospital, some having been there since November. All were said to be recovering well.

There are 16 initiates at Cofimvaba Hospital and all were reported to be in a satisfactory condition. Eight are undergoing treatment at Hewu Hospital in Whittlesea. — DDR

# Initiates to go for skin grafts

Tribal 1997-01-11

QUEENSTOWN — Two of the 17 circumcision initiates at Glen Grey Hospital in Lady Frere are to be transferred to Frere hospital in East London next week for skin grafts, a hospital spokesman said yesterday.

All the other initiates were reported to be in a satisfactory condition.

There are 14 initiates at Cofimvaba Hospital, none of whom was said to be critical. Eight are still being treated at Hewu Hospital, in Whittlesea, while eight others have been discharged from Cala Hospital. Three initiates have died as a result of infection from botched circumcisions. — DDR

# Lusikisiki initiates: plans to fly in docs under way

Tribal

UMTATA — Arrangements are being made to fly in specialist surgeons to St Elizabeth Hospital in Lusikisiki from Cape Town to assist in performing operations on the remaining initiates who sustained injuries in a botched operation by a traditional "surgeon" two weeks ago, the hospital's reproductive health co-ordinator, Ms Lulama Ngomane, said yesterday.

Ms Ngomane said the surgeons will be flown in under the auspices of the South African Red Cross (SARC) in Cape Town.

The general manager of the SARC, Mr John Stone, confirmed from Cape Town that arrangements of that nature were under way.

He said he could not say at this stage when the doctors will be sent to Lusikisiki or how many.

Ms Ngomane said two of the initiates will require skin grafts, three others will have their genitals amputated.

Two were doing well and one was still mentally deranged.— DDR

# 46 circumcision initiates now in EC hospitals

1996-12-18

Tribal

Daily Dispatch Reporters

EAST LONDON — Two more critically ill Xhosa initiates were admitted to hospitals in the northern region of the Eastern Cape on Monday, bringing to 46 the number admitted since the long weekend.

The two were admitted to the Nqamakwe community hospital.

Medical spokesmen said they expected the figure to rise even further before the end of the week.

All were the result of botched circumcisions, the traditional Xhosa rite when youths enter manhood.

Numbers of initiates have been admitted to various hospitals in the region and were still being treated yesterday, while some in less serious condition had been discharged.

Three initiates admitted to Tafalofefe Hospital in Centani were in a critical but stable condition.

One of two initiates admitted to Cala Hospital at the weekend was reported to be in a serious condition.

Frere Hospital spokesperson Walter Makhonjwa said nine initiates there were receiving medical treatment for infections.

Mr Makhonjwa said one of the initiates suffered from a psychological disturbance. The other initiates were admitted for botched surgeries that resulted in complications.

Two initiates would undergo skin grafts. There was no danger of the initiates having their penises amputated, Mr Makhonjwa said.

The circumcision ritual occurs mainly during school holidays to allow initiates to spend a few weeks in the bush.

Five initiates were admitted to Greys Hospital in Queenstown for similar treatments.

A spokesman for the hospital, Dr Steve Molaoa, said two of the initiates had been in danger of having their penises amputated due to infection, but this had been avoided.

One of the initiates was mentally ill.

Dr Molaoa said most of the initiation problems were due to lack of care and ignorance by parents.

He said most traditional doctors circumcised initiates in the bush when they were drunk.

Septic complications led to urinal and kidney dysfunction because initiates had to spend a week or more without drinking water.

Dr Molaoa said in June and July this year, a number of initiates had their penises amputated.

"Once amputation takes place, manhood ceases to exist. The victim experiences psychological problems and extreme emotional depression which can lead to mental breakdown."

Three initiates were admitted to Cecilia Makiwane Hospital at the weekend, bringing the total there to six. One was admitted to Bisho Hospital and was reported to be in a stable condition.

CASE STUDY C.

# Good news for 26 initiates

By Stan Mzimba

LUSIKISIKI — Twenty-six of the 62 initiates who suffered serious injuries during a botched bush operation by a traditional doctor here last month were operated on by a team of doctors at St Elizabeth's Hospital here at the weekend.

The specialists were flown in from Cape Town.

On Saturday, the team performed 22 operations. Three doctors, led by a plastic-and-reconstruction surgeon, Dr J. A. Engelbrecht, moved into the theatres at 9 am.

After lunch and a short break, the doctors returned to the theatre to continue their work until 8 pm.

By 9 am yesterday, the team, backed by local doctors, was back in the theatre to work on the four remaining initiates.

Members of the media, wearing theatre gowns, shoes and caps, were allowed to move freely in and out of the theatres during operations.

During one of the breaks, Dr Engelbrecht said in his 22-year profession he had never worked on so many patients in such a short space of time.

He said a lot of damage had been done to some of the initiates. Two had had the tips of their penises cut off.

He hoped a tragedy of this nature would not happen again.

"I do not say that people should not observe their circumcision tradition, but they must do it properly."

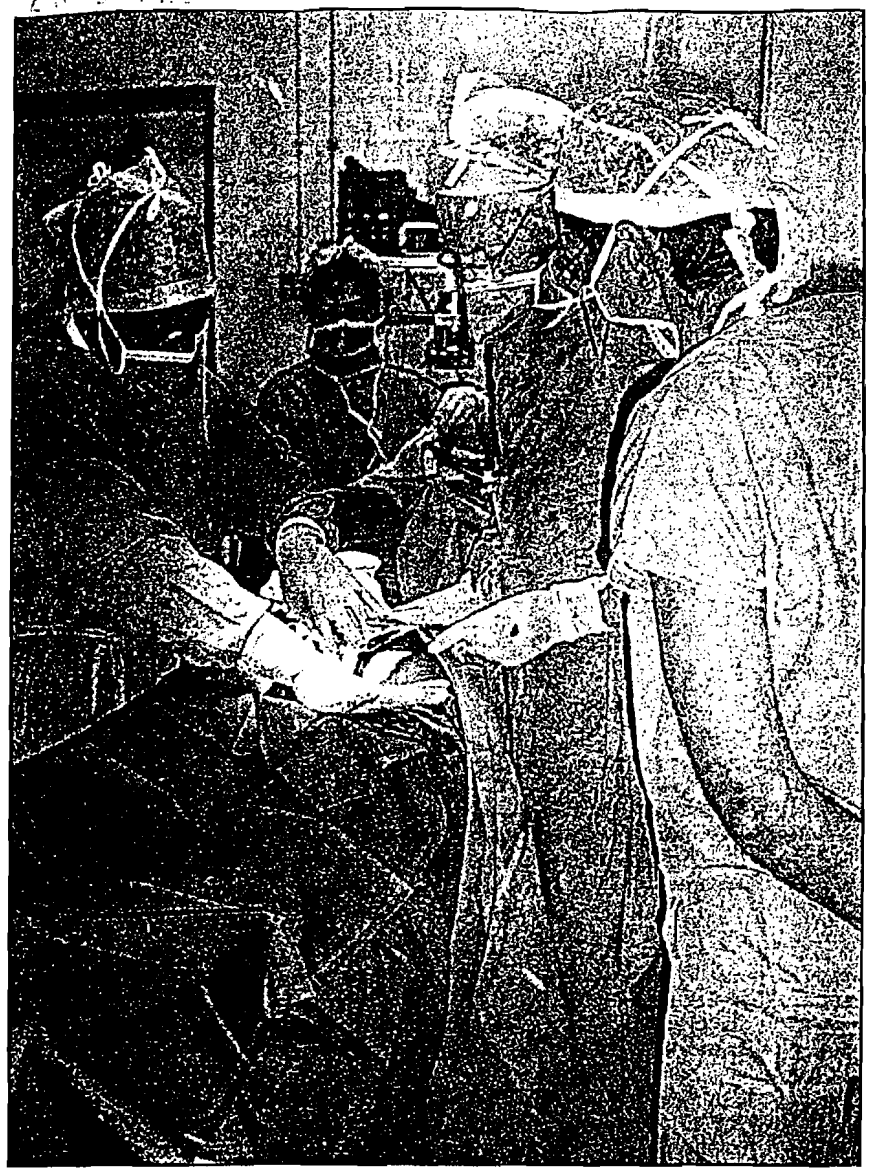
The hospital's superintendent, Dr T. C. Thomas, said none of the initiates will lose his manhood, and all 26 patients who received plastic surgery at the weekend would take about three months to recover fully.

The specialists were flown in and funded by the South Africa Red Cross Air Ambulance Services, whose executive member, Mr John Stone, accompanied them to Lusikisiki.

● Two other initiates died at St Elizabeth's Hospital shortly after their admission, and a third died at his home.

A 37-year-old bush doctor, Mr Siyavuya Mbalo, has since appeared in court charged with three counts of murder.

He was granted bail of R500, but opted to remain in custody for his safety.



**RECONSTRUCTION: Specialist doctors flown from Cape Town operate on an initiate in the St Elizabeth's Hospital in Lusikisiki.**

# Police search for missing initiate

Daily Dispatch Reporter

EAST LONDON — Police are looking for a 20-year-old Needs Camp man who went missing after attending an initiation ceremony there last month.

Mr Sipiwo Zibi and a group of other initiates had been cutting grass to build straw shacks when he stopped to rest, complaining he was feeling ill.

Mr Zibi, who is a Standard 9 pupil at the Lingelethu High School in Needs Camp, was last seen by his companions, who left him there when he sat down to rest, the Border police liaison officer, Lieutenant-Colonel Garry Neuwenhuis, said.

His disappearance was later reported to the person in charge of the initiates and a search was conducted, but he could not be found.

Mr Zibi is 1,8 m tall with black hair and has a slender build.

He was wearing a blanket and an animal skin necklace around his neck.

Anyone with information on his whereabouts can contact Sergeant Sam Majikela on (0431) 43 4400.

# ANC advocates initiates' rights

Tribal

PIETERSBURG — Boys should have the right to decide if they want to be subjected to ritual circumcision, the ANC in Northern Province said yesterday.

A spokesman, Mr Ian Madikoto, urged traditional leaders to ensure the highest standards of hygiene were adhered to in ritual circumcisions.

He congratulated Premier Ngoako Ramathlodi and provincial Safety and Security MEC Seth Nthai on taking firm action against individuals "abducting and circumcising people against their will".

"We regard these practices as sheer barbarism," he said.

On behalf of the ANC he expressed condolences to the families of boys who died from infections caused by the rituals.

2 AUG 1995

Our commissioner for traditional authorities, Mr Benny Boshielo, has held a number of meetings with chiefs and has urged them to ensure these rites are carried out in consultation with the Health Department to avoid the spread of dangerous diseases and deaths.

"We therefore urge all traditional leaders to ensure the highest standards are adhered to with regard to hygiene when initiates are circumcised."—Sapa

# Teen forced to go initiation

By Mthobeli Mxotwa

MDANTSANE — The custom of circumcision took a turn when a teenager, who already underwent initiation three years ago, went back to the abakhwetha school at Zone 6 to undergo the same controversial operation.

He undertook to do this because his peers had ostracised him for having gone to hospital while a abakhwetha three years ago.

The latest development has been heavily condemned by community leaders who called on the residents to put the safety of their children first.

The mother of the 16-year-old, who may not be named for ethical reasons, said she was deeply worried because her son was reported to have escaped from the initiation school on Sunday night and was suspected to be in hospital again. She said he first underwent circumcision when he was 14 years old.

She alleged that when he returned the first time from the abakhwetha house to his Zone 8 community, his contemporaries at the abakhwetha school started to taunt him, calling him a "bat" which is a derisive name given to a man who has mixed traditional rites and western health technology during circumcision.

She said her son became tired of being looked upon with disdain by Zone 8 youths and two weeks ago had decided to go back to circumcision school to remove the stigma attached to him.

Tribal

The mother said the men nursing her son had only recently reported that he was progressing well adding that she was surprised to hear that he has escaped from the bhuma again.

16 JUL 1997

She alleged that those who operated on her son the second time had never sought permission from the parents.

The family was not considering taking any legal steps against the ingcibi because her son had forced them to circumcise him after threatening to commit suicide if they declined, she said.

She alleged that her son had been behaving strangely recently at the abakhwetha house.

He was reported to have been swallowing poisonous substances including paraffin, she said.

Previously he had been diagnosed by traditional healers to be suffering from evil spirits.

The Zone 8 circumcision bungle has evoked outrage among the community leaders.

Mr Phillip Slotile of Zone 8 said he was deeply disturbed by the trauma to which the youngster had been subjected by his peers.

He called on the parents to take extra care about the safety of the children when undergoing circumcision.

Ostracising an initiate who had taken precautionary measures by seeking health service was uncalled for, he said.

A civic leader, Mr Mzwandile Buzani, condemned the incident and called on the Zone 8 community to unite and prevent a repeat of the incident.

Those involved in these heinous deeds should be prosecuted, he added.

Mr Buzani said parents should put the safety of the children above traditional preferences.

It is believed that it is the first time in Mdantsane that a man has undergone traditional circumcision twice.

# Boys kidnapped for circumcision

11 JUL 1997 Tribal

Daily Dispatch Correspondent

PORT ELIZABETH — Northern Province initiation schools were kidnapping schoolboys at night and circumcising them without their consent, resulting in 12 boys being admitted to hospital and one dying from his injuries, Premier Ngouko Ramatlhodi said yesterday.

Reports of traditional authorities forcing young boys to attend "circumcision schools" were received and some boys were forced to pay a fee of R50 or more, Mr Ramatlhodi said.

Twelve boys had been admitted to the Siloam hospital for infection and severe bleeding and one was reported to have died on Sunday.

Bushdoctors were using one blade to cut more than one boy, heightening the risk of spreading infectious diseases including HIV.

The government was calling on traditional leaders to assist in dealing with the crisis.

CASE STUDY C.

# Initiates enrol without parents' consent

Tribal

LUSIKISIKI — Prolonged teasing among schoolboys at various schools here over the question of circumcision, led a group of young men to enrol themselves as candidates for the "operation" without the knowledge of their parents during the recent winter holidays.

Their attempt to graduate from boyhood to manhood led to botched incidents which left four dead, and others with their manhood amputated.

Traditionally Pondo tribesmen do not recognise circumcision and it is thought the men in the area were enforcing their will not to allow boys to be circumcised.

In desperation, the initiates, mostly schoolboys between the ages of 16 and 21, managed to acquire money to pay the surgeon R25 per initiate. Police said that not a single initiate reported he would be going for circumcision they simply disappeared from their homes.

**NEEDING TREATMENT: Initiates Mzingisi Dumisa, 16, left and Zolisa Lukhalo, 17, right were admitted to St Elizabeth Hospital, in Lusikisiki, recently. Ms Lulama Ngomane (centre) is a senior nurse at the hospital.**

2 AUG 1990

The Reproductive Health Care co-ordinator at the St Elizabeth Hospital, Ms Lulama Ngomane, confirmed that she defied all the traditional rules that prevent females visiting initiates at their camps.

"When I received a report about the crisis I asked the police to escort me to the camps. All I had in mind at the time was to save a life" she said.

She said in the four areas around Lusikisiki where the initiates went there were ten camps. Each camp, had on average between 12 and 13 initiates.

Ms Ngomane said 62 initiates had been taken by police vans to her hospital from the camps .

Of the group, 10 were transferred to Bambisana Hospital, 17 to Holy Cross Hospital, near Flagstaff, eight are still at St Elizabeth, 13 have been discharged, six absconded and four died.

She said of the youths at St Elizabeth, two will require a skin craft, four have had their genitals amputated, one is mentally unstable and four others were on the road to recovery. — DDR

# Circumcision schools: public opinion sought

Tribal

PIETERSBURG — The public have been invited to submit comments to the Northern Province government on its proposed legislation on circumcision schools.

A notice published in the local and national press points out that the proposed bill envisages giving the premier powers to regulate the issuing of permits, and to determine the duration of the schools.

"In line with the Constitution of South Africa, the bill will protect the fundamental rights of citizens, and ensure people are treated with the necessary respect and dignity," it says.

The bill will also give police the authority to rescue people taken to the circumcision schools against their will.

Earlier this month, Premier Ngoako Ramathlodi expressed his concern about deaths which had occurred at some circumcision schools.

24 JUN 1990

A government spokesman said the bill would probably be presented and debated in the provincial legislature within the next two months. — Sapa

CASE STUDY C

# Killing of 3 women linked to initiates

Tribal

UMTATA — Police have been told that the three women who were hacked to death near Libode last week were attacked after a Xhosa initiate, apparently suffering from hallucinations, complained of having bad dreams.

Thirty-seven youths were arrested after the women, Ms Mathunzi Tsipha, 55, Ms Maqoyi Madulini, 55, and Ms Madontsa Mkhutyukelwe, 56, were killed at Makhotyana last Monday night.

A police liaison officer, Constable Nomthanzo Mbangata, said it was alleged that, during his hallucinations, the initiate frequently referred to the women.

Constable Mbangata said the youths allegedly held secret meetings where they discussed killing the women.

A large number of assegai-wielding youths moved from house to house and killed the women one by one.

The initiate who had been hallucinating was reportedly taken to an undisclosed place to be treated by a sangoma.

The arrested youths appeared in the Libode Magistrate's Court and their case was postponed to August 30. — DDR

# Man shot at circumcision

**UMTATA — A 40-year-old man was killed during a circumcision initiation ceremony near Ngqeleni at the weekend.** Tribal

**A police spokesman, Captain Monde Nqadini, said Mr Nompotswana Nange, 40, of Nkanunu administrative area, was fatally shot by a person who fired several rounds, apparently from excitement.**

**A man was arrested and was due to appear in court today on a charge of murder.**

**● A 60-year-old man was found shot at Tshiqo near Tsolo.**

**Capt Nqadini said a revolver and an empty cartridge were found next to the body of Mr Vuyolethu Mhlabeni.**

**Foul play could not be ruled out, he said. — DDR**

# Stabbing death at ritual

QUEENSTOWN — A Whittlesea man will appear in the Whittlesea Magistrate's Court today on a charge of murder following the death of a resident of the town at the weekend. Tribal

A police liaison officer here, Inspector Willem Kitching, said yesterday Mr Mbhebiso Mondrake, 37, was allegedly stabbed to death at a party during a circumcision ceremony. — DDR

15 DEC 1995

# Man killed at ritual

KING WILLIAM'S TOWN — A man was shot dead and a woman was seriously injured when fighting broke out between a group of youths during a circumcision feast in Ezeleni near Zwelitsha on Sunday. Tribal

A police liaison officer, Captain Sibongile Ndyoko, said a man had been arrested and a 9 mm pistol confiscated.

Three suspects were arrested after a man was assaulted with an axe and sticks during an argument in NU 12, Mdantsane, on Monday. — DDR

# Initiate axed to death — arrest

Tribal

Daily Dispatch Reporter

EAST LONDON — A 20-year-old man, Mr Ayanda Nayi, was hacked to death with an axe during a circumcision ceremony at McKay's Nek on Wednesday.

A Queenstown police liaison officer, Captain Thembesile Patekile, said a 20-year-old suspect was arrested on suspicion of murder and was to appear in the Lady Frere Magistrate's Court today.

Meanwhile, at least five patients have been admitted to Frere Hospital in the past week after problems set in following circumcision. 15 DEC 1995

A Sanco health and environment officer, Mr Walter Makhonjwa, who is also a Frere chief professional nurse, said two were from Butterworth and the others from Queenstown, Duncan Village and Indwe.

They were in a serious condition.

Mr Makhonjwa said a patient sent earlier in the week from Indwe had absconded while doctors were preparing to test his blood.

He appealed to parents and relatives to visit circumcision shelters regularly to ensure no health problems had arisen.

Communities should not delay in sending affected patients to hospital and should visit until their condition had improved.

# Police concerned over increase in circumcision killings

Daily Dispatch Reporter

**QUEENSTOWN — Police here have expressed concern at an increasing number of killings during arguments at circumcision ceremonies.**

**About 10 deaths at such ceremonies have been reported in the area during the past few months, a police liaison officer here, Captain Thembisile Patekile, said yesterday.** Tribal

**In separate incidents in November and December last year, Molosi Mtyoki, 14, and Sakumzi Matshoba, 18, died while stick-fighting at ceremonies in the Idutywa and Nqamakwe districts.**

**Mr Mzwabantu Sokuphe was stabbed to death during a ceremony at Cegcuwana village in November, while Mr Mbhebiso Mondraka died from a stabbing at a ceremony in Whittlesea in December.**

**Capt Patekile appealed to the public to come forward with suggestions on how to stop the violence at the ceremonies.** 3 JAN 1996

**He said community policing in the surrounding areas should be used to combat the incidents.**

CASE STUDY C.

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# CIRCUMCISION: SUCCESSFUL GLANULAR RECONSTRUCTION AND SURVIVAL FOLLOWING TRAUMATIC AMPUTATION

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ABSTRACT

Purpose: Circumcision remains the most common operation performed on male individuals in the United States. Unfortunately various complications may occur during circumcision ranging from trivial to tragic. We report 7 cases of traumatic amputation of the glans penis and/or urethra during circumcision. In addition, errors in circumcision technique as probable mechanisms of injury, principles of repair and limits of tissue viability are discussed.

Materials and Methods: The medical records of 7 patients who underwent traumatic circumcision amputation of the glans penis and/or urethra were reviewed. Glanular amputation occurred in 6, 8-day-old neonates during ritual circumcision and in 1, 5-month-old infant circumcised by a physician.

Results: Excised glanular tissue remained viable up to 8 hours after injury. Followup ranged from 8.5 to 108 months. All patients had an acceptable cosmetic result. No long-term complications developed in the 8-day-old group but a distal urethral fistula formed in the 5-month-old patient.

Conclusions: Careful selection of technique and device as well as strict attention to detail at circumcision should eliminate most injuries. On the basis of our results we recommend reanastomosis of the glans and/or urethra following distal amputation even when there is a delay in surgical repair of up to 8 hours.

KEY WORDS: penis, circumcision, wounds and injuries

Circumcision is one of the oldest and most common operations known to mankind.[1] In 1987 the National Center of Health Statistics found that 61% of 1.19 million male individuals born in the United States were circumcised.[2] Historically this operation has been traced to ancient Egypt with the finding of circumcised mummies in the tombs of Ankh-Mahor.[3] Bris milah, a Jewish ritual circumcision, has been performed throughout the centuries by a medically and religiously trained specialist, the mohel. Maimonides reviewed the basic steps of excising the foreskin, tearing the mucosa and exposing the glans penis.[4] This tradition marks a rite of passage into Judaic childhood.

Routine circumcision of the newborn carries a small risk of complication. Complications involving glanular amputations are rare. We report traumatic glans amputations with and without urethral amputations in 6, 8-day-old white neonates and 1, 5-month-old black infant during circumcision. In addition, the results of penile, glanular and urethral reconstruction are discussed.

## CASE HISTORIES

Six 8-day-old white neonates and 1, 5-month-old black infant underwent circumcision. To our knowledge no patient had significant medical history and all had progressed through an uneventful term gestation without complications. The site and extent of injury, elapsed time from injury to repair and complications are shown for each patient in the table. Circumcision was performed freehand in patient 5, with the aid of a Mogen clamp (fig. 1, *A*) in patient 2 and with a protective shield (fig. 1, *B*) in the remainder. Glanular injuries ranged from partial amputation to nearly two-thirds glanular amputation with severe shaft degloving in patient 6 (fig. 2). In addition, 5 patients had distal urethral amputation. Figure 3 illustrates all injuries encountered.

In 6 of the 7 cases the amputated tissue was available at the time of repair, often received at the hospital in moist gauze. In patient 5, who was 5 months old at circumcision, the glans and distal urethra were excised and then reanastomosed by the referring surgeon. This patient was referred 2 days later when the stenting urethral catheter migrated into the bladder, and at followup he was the only patient to have a urethral fistula. The site of the fistula was along the glans anastomotic suture line. In 1 patient the nearly amputated glans remained attached by a thin bridge of skin and was viable after reconstruction. Elapsed time from amputation to operative repair for the 7 patients ranged from immediate (within 30 minutes) to 8 hours (mean 4.6 hours).

All potentially viable amputated tissue was inspected in-

*Details of traumatic injury at circumcision and followup*

| Pt. No. | Age at Circumcision | Injury | Hrs. From Injury to Repair | Complication |
|---|---|---|---|---|
| 1 | 8 Days | Amputation of distal glans and distal urethra | 6 | None |
| 2 | 8 Days | Tangential amputation of lt. hemi-glans with penile shaft skin degloving | 4.5 | None |
| 3 | 8 Days | Tangential partial amputation of distal glans (rt. greater than lt.) and distal urethral amputation | 5 | None |
| 4 | 8 Days | Amputation of distal glans and distal urethra | 4 | None |
| 5 | 5 Mos | Amputation of distal glans and distal urethra | 0.5 | Postop. retraction of urethral stent and distal urethral fistula |
| 6 | 8 Days | Amputation of two-thirds of distal glans and distal urethra | 4 | None |
| 7 | 8 Days | Tangential amputation of ventral glans and ventral degloving from corona to base of penis | 8 | None |

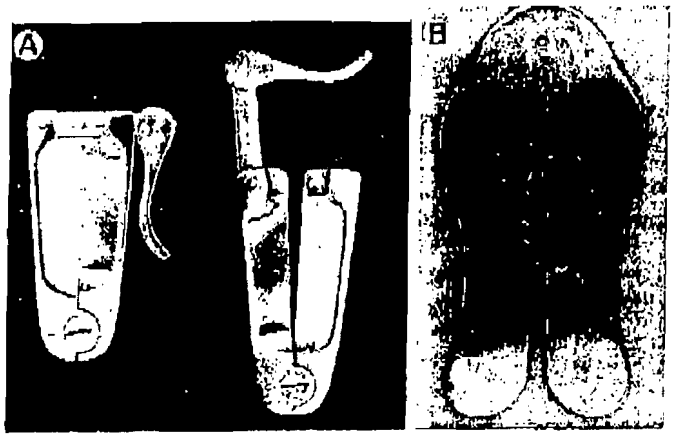


FIG. 1. *A*, Mogen clamp. *B*, shield

FIG. 2. Patient 6. Nearly two-thirds glanular amputation with shaft degloving. Note catheter passed through distal urethra.

traoperatively and irrigated with a copious amount of normal saline. Occasionally minimal débridement was necessary before repair. The penile shaft, glans and urethra were carefully inspected for potential nonviable or devascularized regions. In the patients with more extensive injuries a pediatric feeding tube was passed via the urethra to aid in identification and repair of suspected urethral injury. Surgical repair in 6 of the 7 cases involved simple primary anastomosis of the amputated glans; urethral reanastomosis was required in 5 of the 7 cases. In patient 7 with amputation of the ventral glans with the distal two-thirds of ventral penile shaft skin the exposed but uninjured urethra and meatus were covered with the excised tissue. In patient 3, in whom the excised glans was not available for reanastomosis, the sides of the wedge-like defect were reapproximated.

Six or 7-zero chromic catgut and polyglactin suture material was used in all repairs. Two to 4 sutures were used for urethral anastomosis. In addition, in patients with urethral injury and repair the urethra was stented with a silicone catheter or feeding tube. Stents were removed 3 to 5 days postoperatively. Perioperatively parenteral broad-spectrum antibiotics were given prophylactically. There were no wound infections. Followup ranged from 8.5 to 108 months (mean 41.6). Cosmetic results have been encouraging in all patients at short-term followup, including patient 3, who perhaps had the most severe injury (fig. 4). In patient 5, in whom the glans and urethra were reanastomosed by the referring surgeon, a glanular urethral fistula formed at the ventral glans repair site. In patient 7 the amputated ventral glans and skin covering the urethra were reanastomosed 8 hours after injury. Five days postoperatively the repaired area appeared devitalized. However, 2 weeks postoperatively the glans and penis were covered with healthy tissue.

## DISCUSSION

Currently neonatal circumcision is performed in approximately 65% of all male infants in the United States.[1] Circumcision is usually a safe and simple procedure with minimal associated morbidity when performed correctly. As with any surgical procedure, complications inevitably occur. The true incidence of complications following routine neonatal circumcision is unknown, primarily due to small insignificant iatrogenic injuries that are managed by basic medical first aid treatment and wound pressure, and that rarely require a suture. Gee and Ansell,[5] and Harkavy[6] reported neonatal circumcision complication rates of between 0.2 and 0.6%. However, this rate has been shown to increase with the performance of circumcision later in childhood.[7]

The most common complication of circumcision is bleeding,[6] which has a reported incidence of between 0.1 and 35%.[8] Most of these episodes are controlled with the use of wound pressure.[1] Inherently successful circumcision requires that an adequate amount of preputial tissue be excised. Errors in the amount or proper angling of the area of excision occasionally occur. However, partial penile amputation during circumcision is rare. Historically the first genital reconstruction involving an extreme case of complete penile amputation and replantation was reported in 1929.[9] Accidental, iatrogenic and self-inflicted amputations of the male genitalia have

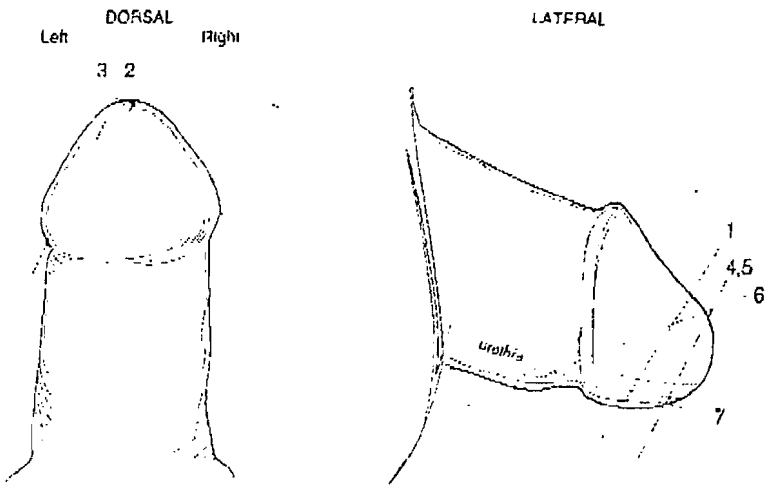


FIG. 3. Amputation injuries. Numbers and dotted lines represent patients and corresponding injuries.

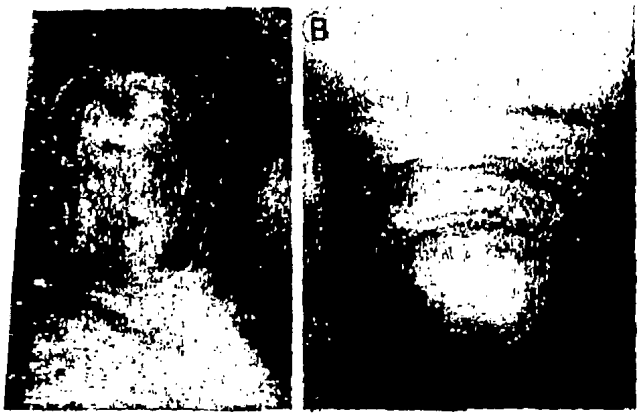

FIG. 4. Patient 3. Result of glanular reconstruction at 10 months postoperatively. *A*, ventral aspect of penis. *B*, dorsal aspect of penis.

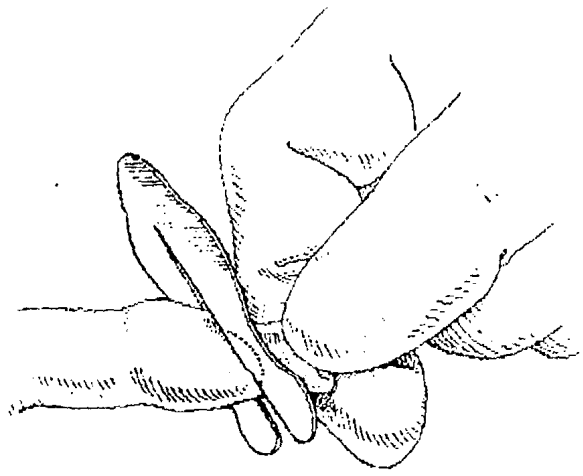

FIG. 5. Protective shield at oblique orientation angled parallel to corona with foreskin pulled distally

ven previously described in the literature.[10-13] In the past ttempts at reconstruction and replantation were discouraged ue to poor surgical outcome after restoration efforts. Viability f the amputated organ or tissue was directly related to the lapsed time between injury and repair, availability of microeurovascular surgery and extent of injury.[11,12]

The antegrade and retrograde dual blood supply to the glans penis and corpora spongiosum, supplied by the dorsal and urethral arteries, provides an excellent source of vascularity to our imposed graft or flap. Standard plastic surgical reconstructive principles with intraoperative débridement of nonviable tissue and meticulous reapproximation of traumatized tissue edges were performed in all patients.

The method of ritual circumcision varies depending on the religious customs observed by the mohel and family. The foreskin is freed and advanced beyond the glans. At this point the mohel may use a Mogen clamp or protective shield usually placed at an angle parallel to the corona, that is at an oblique orientation lying more proximal on the dorsum than ventrum. The foreskin is pulled through the open clamp or shield (fig. 5). When the Mogen clamp is used, it is closed to crush the tissue for hemostasis, and the foreskin is then excised with a scalpel just distal to the clamp (fig. 1, *A*). Some traditional mohels believe that crushing the skin does not follow religious dictates and instead they excise the skin on the distal side of the shield or excise the foreskin without a shield. They compress the foreskin between the fingers just beyond the tip of the glans to protect the glans, and then excise the foreskin. If the ventral foreskin is advanced too far distally, it may pull up on the frenulum, which in turn will bring the urethral meatus and ventral glans forward as well. When this happens, a portion of the glans may be excised with the ventral penile and frenular skin attached to it. This is the proposed mechanism of injury for the majority of our patients. Repair of these more severe injuries requires reanastomosis of the glans and frenulum, and sometimes the urethra.

According to the medical history, in patient 7 the foreskin was excised with the protective shield placed at an angle almost perpendicular to the corona. The ventral glans was amputated with a significant amount of ventral shaft skin, exposing an intact urethra. A patch of excised skin and the ventral glans were reanastomosed 8 hours after injury. Five days postoperatively eschar formation was visible at the site of repair. However, at further followup normal tissue had grown, and the urethra was completely intact and covered. Perhaps the reanastomosed tissue that appeared nonviable at initial followup provided a scaffold for normal tissue healing. Based on our experience we recommend reanastomosis of excised penile tissue when available even up to 8 hours after circumcision injury.

Ann Erikson provided computer graphics.

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