NEDERLANDSE VERENIGING VOOR UROLOGIE

Standpunt ten aanzien van de indicaties voor circumcisie van de Nederlandse vereniging voor urologie (NVU)

Inleiding

Het Bestuur van de NVU heeft opgemerkt dat in den lande behoefte is aan een standpunt over de indicaties van circumcisie. De urgentie is hoog door de maatschappelijke en politieke discussie die hierover heerst.

Dit standpunt is mede tot stand gekomen door de uitspraak van Minister Schippers in november 2013. Zij heeft toen het volgende aangegeven: *In de media brengen urologen verschillende meningen naar voren over het aantal besnijdenissen dat vanwege medische noodzaak plaatsvindt. Daarom acht ik de totstandkoming van een eenduidige behandelrichtlijn essentieel. Ik roep de Nederlandse Vereniging voor Urologie (NVU) op hiertoe het initiatief te nemen. De verantwoordelijkheid voor het opstellen van een richtlijn ligt bij de beroepsgroep zelf en het is dus ook aan de beroepsgroep zelf op welke termijn een dergelijke richtlijn tot stand komt en in werking kan treden. In dit stadium waarin er nog geen eenduidige behandelrichtlijn is wat onder een medisch noodzakelijke besnijdenis valt en wat niet, kan ik geen enkele uitspraak doen over eventuele mogelijkheden om de toegang tot medisch noodzakelijke besnijdenissen te waarborgen.*

De hieronder vermelde indicaties voor circumcisie bij volwassenen en kinderen zijn opgesteld op advies van de werkgroepen kinderurologie en andrologie van de NVU. Dit standpunt richt zich alleen op die situaties waarin circumcisie is geïndiceerd. Het Bestuur van de NVU heeft onderstaand standpunt vastgesteld op basis van de reacties van een ledenraadpleging en een commentaarronde. Uit de consultatieronde bij de leden blijkt een groot draagvlak te zijn voor deze indicaties.

1. Medisch noodzakelijke circumcisie bij volwassenen

1. Papulosquameuze afwijkingen van glans en preputium
    - Zoon balanitis, ook wel plasmacel balanitis[i]
2. Chronische infectieuze afwijkingen
    - Recidiverende balanitis en balanoposthitis niet goed reagerend op conservatieve therapie[ii]
3. Klinische verdenking op een (pre)maligne afwijking wanneer een lokale excisie niet mogelijk is zoals
    - Lichen Sclerosis[iii]
    - Plaveiselcel carcinoma (in situ)[iv]
    - Verruceus carcinoom (Buschke-Löwenstein tumor) [v]
4. Phimosis die leidt tot seksuele en/of hygiënische klachten

2. Medisch noodzakelijke circumcisie bij kinderen (tot 16 jaar)

1. Phimosis met (verdenking) Lichen Sclerosus
2. Phimosis met recidiverende balanitiden èn onvoldoende resultaat na 2 sessies van 6 weken corticosteroïden klasse 4 met progressieve retractie

3. Recidiverende UWI's bij jongens met congenitale afwijkingen van de urinewegen (bijv. kleppen, hooggradige reflux, mega-ureter)
4. Recidief phimosis na preputiumplastiek
5. Niet-redresseerbare paraphimosis
6. Recidiverende balanitiden en/of recidiverende UWI's bij patiënten die dagelijkse hygiënische verzorging niet toelaten (bijv. ernstige retardatie, autisme e.d.)
7. Persisterende phimosis die (aanleren van) zelfkatheterisatie bij jongens belemmert èn onvoldoende resultaat van 2 sessies van 6 weken corticosteroïden klasse 4 met progressieve retractie
8. Symptomatische phimosis i.c.m. andere ernstige pathologie (oncologisch; immunologisch etc.)

Voetnoten (referentie Campbell Urology)

[i] Zoon balanitis, also called plasma cell balanitis, occurs in uncircumcised men from the third decade onward (Pastar et al, 2004). Smooth, moist, erythematous, well-circumscribed plaques on the glans penis characterize the disease (see Fig. 15–42). Shallow erosions may also be present (Yoganathan et al, 1994), and the lesions can be quite large (up to 2 cm in diameter) (Margolis, 2002). Squamous cell carcinoma and extramammary Paget disease should be excluded, often by biopsy. Circumcision appears to be proof against development of the disease and can be performed to cure the majority of cases (Sonnex et al, 1982a; Ferrandiz and Ribera, 1984). For patients averse to circumcision, topical corticosteroids may provide symptomatic relief, and topical tacrolimus and laser therapy may also have a role (Baldwin and Geronemus, 1989; Tang et al, 2001; Albertini et al, 2002; Retamar et al, 2003; Wojnarowska and Cooper, 2003; Rallis et al, 2007).

[ii] Balanitis is an inflammatory disorder of the glans penis. When the process involves the preputial skin in uncircumcised men it is termed balanoposthitis. In children, bacterial infections are the predominant cause. In adult men, the cause may be intertrigo, irritant contact dermatitis, local trauma, or candidal and bacterial infections (Fig. 15–21). Treatment includes removal of irritating agents, improved hygiene, topical antibiotics, and antifungals and, occasionally, short courses of low-potency topical corticosteroids (Margolis, 2002). When treatment fails, the differential should include neoplastic diseases, Zoon balanitis, psoriasis, and alternative infectious agents such as papillomavirus (Wikstrom et al, 1994). Balanoposthitis tends to occur in patients with phimosis, and circumcision may be curative in select recurrent cases.

[iii] Lichen sclerosus et atrophicus (LS) is a chronic inflammatory disease with a predilection for the external genitalia. LS is 6 to 10 times more prevalent in women than in men, generally presenting around the time of menopause (Wojnarowska and Cooper, 2003). For patients with genital LS, 15% to 20% have extragenital disease (Powell and Wojnarowska, 1999). LS is a scarring disorder characterized by tissue pallor, loss of architecture, and hyperkeratosis (Fig. 15–12). It tends to affect older men (>60 years of age) (Ledwig and Weigand, 1989) and can be associated with pain during voiding or erection (Margolis, 2002). The glans penis and foreskin are usually affected, and the perianal involvement common in women is usually absent. Preputial scarring from LS can lead to phimosis, and circumcision is usually curative, although recurrence in the circumcision scar may occur. The late stage of this disease is called *balanitis xerotica obliterans*, which can involve the penile urethra and result in troublesome urethral stricture disease. Despite the similarities in name, LS shares little in common with LP and LN other than pruritus and a predilection for the genital region. Another critical distinction is that LS has been associated with squamous cell carcinoma of the penis, particularly those variants not associated with human papillomavirus, and may represent a premalignant condition (Velazquez and Cubilla, 2003; Bleeker et al, 2009). LS has specific histologic features, including basal cell vacuolation, epidermal atrophy, dermal edema, collagen homogenization, and focal perivascular infiltrate of the papillary dermis, and plugging of the ostia of follicular and eccrine structures (Margolis, 2002). Biopsy is worthwhile both to confirm the diagnosis and exclude malignant change (Powell and Wojnarowska, 1999). From a management standpoint, long-term follow-up of patients with LS is important due to the association with squamous cell carcinoma. The application of potent topical steroids (such as clobetasol propionate 0.05%) for long courses (3 months) is well established as a treatment for LS in women and may both improve symptoms and reverse the disease process (Dalziel et al, 1991) This regimen is contrary to the usual policy of avoiding long courses of steroid application to genital skin. The efficacy of similar approaches has not been confirmed in adult men, although benefits have been demonstrated in the pediatric age group (Kiss et al, 2001). A recent European, multicenter, phase II trial also supported the safety and efficacy of topical tacrolimus in the treatment of long standing LS (Hengge et al, 2006).

[iv] Squamous cell carcinoma in situ (SCCis) is a full-thickness intraepidermal carcinoma (Miller and Moresi, 2003). Bowen originally described this condition in 1912, hence the term “Bowen disease” (Bowen, 1912). On extragenital sites, there is a strong association between SCCis and ultraviolet light exposure (Reizner et al, 1994). Commonly presenting in the seventh decade of life with a slight female predominance (Hemminki and Dong, 2000; Arlette, 2003), SCCis usually has an indolent clinical course and rarely progresses to invasive disease. When it occurs on mucosal surfaces of the male genitalia, most notably the glans penis of uncircumcised men, this entity is referred to as erythroplasia of Queyrat (Fig. 15–33). In that location, coinfection with human papilloma virus types 8, 16, 39, and 51 has been identified (Wieland et al, 2000). Other risk factors for SCCis include ionizing radiation, immunosuppression, thermal injury, arsenic exposure, chronic dermatoses, and lichen sclerosis of the glans penis (Euvrard et al, 1995; Nasca et al, 1999; Powell et al, 2001; Centeno et al, 2002; Arlette, 2003). SCCis lesions are sharply demarcated, solitary, pink to red, scaly plaques that may be confused with basal cell carcinoma, eczema, or psoriasis. When localized to the penile shaft, SCCis may have a more thickened, verrucoid appearance. Although usually asymptomatic, these lesions may also be pruritic or painful. The diagnosis is confirmed by histologic evaluation, and several areas should be sampled to exclude the presence of dermal invasion (Margolis, 2002). Primary treatment of SCCis involves either surgical excision or tissue ablation. For accessible areas, such as the scrotum, simple excision with a 5-mm margin is favored (Bissada, 1992; Margolis, 2002). For areas where tissue preservation is more critical, Mohs microsurgery, laser therapy and cryoablation may have a role (Sonnex et al, 1982b; van Bezooijen et al, 2001;

Leibovitch et al, 2005). Topical treatment with either 5-fluorouracil or imiquimod has also proven effective for management of selected cases of SCCis involving the genitalia (Gerber, 1994; Arlette, 2003; Micali et al, 2003).

[v] Verrucous carcinoma (VC) is a locally aggressive, exophytic, low-grade variant of squamous cell carcinoma that has little metastatic potential (Habif, 2004). The Buschke-Lowenstein tumor is a VC of the anogenital mucosal surface and may represent up to 24% of all penile tumors (Schwartz, 1995). It most commonly occurs in uncircumcised men on the glans or prepuce, although similar lesions can be found on the vulva, vagina cervix, or anus. VC has been associated with human papilloma virus types 6 and 11 infection, but not with the more classically oncogenic types 16 and 18 (Yasunaga et al, 1993; Chan et al, 1994; Margolis, 2002; Ahmed et al, 2006).
VC lesions have a warty appearance and are often large and fungating when presenting on the genitalia (Fig. 15–36). Aside from genital sites, these lesions can also present within the oral and nasal cavities and plantar surfaces of the feet. They are slow-growing and locally destructive, often extending deeply into underlying tissue. Treatment is preferably by local excision. Primary radiotherapy is relatively contraindicated due to the potential for anaplastic transformation with a subsequent increase in metastatic potential (Stehman et al, 1980; Andersen and Sorensen, 1988; Fukunaga et al, 1994; Vandeweyer et al, 2001).