Letters
Correspondance

Foreskin management

What an excellent article by Metcalfe and Elyas![1] The authors were absolutely correct in noticing from their own urology practices that family doctors face a lot of uncertainty and patient concern about foreskin normality and abnormality. This paper did an excellent job of summarizing the common concerns about and management of foreskins, while detailing the uncommon but not-to-miss balanitis xerotica obliterans. The scenarios and pictures made the article very readable and interesting. I believe I have a much better understanding of how to counsel patients and how to spare urologists unnecessary referrals. Thanks!

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Reference

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Gairdner was wrong

Metcalfe and Elyas have produced a truly excellent paper[1] that should become a classic. We would recommend it to anyone.

Having said that, we do have one quibble with this paper. The authors cited Wright[2] when discussing complications of circumcision. Wright also said the following:

> Gairdner's otherwise masterly description contained one inaccuracy. He said that the foreskin should be fully retractable by three years of age. Clinical observation reveals that this is not true. It should be open and beginning to retract by three years of age but full retractability may not be achieved [until] many years later. Indeed nature will not permit the assignment of a strict timetable to this process.[2]

Inexplicably, Metcalfe and Elyas then quoted Gairdner's inaccurate figures on the development of foreskin retractility.

Gairdner, for whom we generally have the very highest respect, reported in *his* classic paper that he used a probe to break the normal fusion between the inner surface of the foreskin and the underlying glans penis to create a retractable foreskin, and thus avoid a circumcision.[3] But he also said that "it is inadvisable as a routine procedure."

Gairdner's bar graph shows a steep increase in retractility from birth to age 3 years. This does not occur in nature; it is possible that these values were obtained by the use of the probe. In any event, they have been disproved by later research. In actuality, development of retractility tends to be much slower.

Gairdner's values for the development of foreskin retractility stood alone and unchallenged for decades, during which they were quoted by the authors of numerous textbooks.[4] Unfortunately, thousands of physicians the world over have been trained with these false values. This undoubtedly has contributed to false diagnoses of pathological phimosis and large numbers of medically unnecessary amputations of healthy nonretractile foreskins in many nations.

Øster,[5] Kayaba et al,[6] Morales Concepción et al,[7] Agarwal et al,[8] and Ko et al[9] all have demonstrated that the development of preputial retraction is a very gradual and variable event that occurs between birth and the completion of puberty. Moreover, Thorvaldsen and Meyhoff carried out a survey in Denmark and reported that the mean age of first foreskin retraction is 10.4 years.[10] All of these authors provide evidence that refutes Gairdner's 1949 data.

Gairdner's values for foreskin retraction belong in a museum of medical history, but they should not be applied in current clinical practice.

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References

1. Metcalfe PD, Elyas R. Foreskin management. Survey of Canadian pediatric urologists. *Can Fam Physician* 2010;56:e290-5. Available from: **www.cfp.ca/cgi/reprint/56/8/e290**. Accessed 2010 Sep 9.
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Sensitive to emotional needs

I read with interest the debate "Should family physicians be empathetic?"[1,2]

In my opinion, trying to debate the issue around the definition of empathy, as your authors have done, amounts to more of an attempt to split hairs. I believe that the issue should be focused more on the question of ensuring that family physicians are sensitive to their patients' emotional needs. I am not sure how to best train physicians to optimize their sensitivity, as so much is determined, I believe, by personal experience.

In my own case, I became a better physician (and person) after experiencing the loss of my spouse 4 years ago to cancer. It brought a sensitivity to others in the same situation that I could not have developed otherwise. Life experiences do give us a wisdom that cannot be obtained academically. This does not mean that we must relive our emotional experiences in dealing with others who are experiencing what we have experienced (although it did help me to achieve appropriate emotional distance by working through my grief with personal therapy), but rather our experiences give a true understanding of what the patient is experiencing (which I believe is as good a definition of empathy as any).

Training residents and medical students, not to mention practising physicians, to be sensitive to patients is a difficult task. Narrative medicine is an excellent way of exposing the life experiences our