Re: History of Circumcision, Medical Conditions, and Sexual Activity and Risk of Penile Cancer

If one were to read an article beginning, "Epidemiologic evidence suggests that a failure to remove the female breasts in infancy is the strongest risk factor for breast cancer," might one not feel compelled to offer a defense of the intact breast? An article with an analogous statement appeared recently in this journal (1). The article began: "Epidemiologic evidence suggests lack of neonatal circumcision as the strongest risk factor for penile cancer.""

The opening statement of this article is likely to be used to promote circumcision, even though the study finds other risk factors for penile cancer independent of circumcision status and fully recognizes that penile cancer occurs in circumcised individuals; cancer originated in the circumcision scar in one case. Authors must be mindful of this risk when presenting data relating to this unnecessary surgical procedure.

Even if the foreskin were to be implicated in penile cancer, it should not be removed. It is absurd and tragic to remove 99,999 normal foreskins to prevent the possibility of one cancer of the penis in an older man.

In defense of the foreskin, an integral part of the mammalian penis, it has functions that have never been understood by members of the American medical profession. For example, in infancy, the foreskin is still attached to the glans penis and may remain so normally until 17 years of age. It should never be forcibly retracted and will gradually become retractile on its own. It protects the glans and prevents it from cornifying. It also protects the meatus from stenosing (2,3).

As the intact boy matures, the foreskin begins to perform another rather vital function. It serves as the skin for the enlarged, erect penis, providing the surface mobility decreed by millions of years of evolution.

Last, but hardly least, it is now known that the foreskin contains Meissner's corpuscles, complex nerve endings also found in breast papillae, that contribute to sexual pleasure (4).

It is quite unnecessary to remove the foreskin. The 250 million European men who have virtually all grown up intact, are testimony to this fact (5). In presenting studies of this important organ, extra care must be taken due to the irrational behavior surrounding the performance of circumcision in the United States.

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References

(2) GAINORNER D: Fate of the foreskin. Br Med J 2:1433, 1949
(3) SPOCK B, ROTHEINEBERG MB: Dr Spock's Baby and Child Care, 6th ed. New York: Simon and Schuster, 1992, p 227
(5) DENNISTON GC: Unnecessary circumcision. The Female Patient 17:13-14, July 1992

Re: Decision Analysis of Hematopoietic Growth Factor Use in Patients Receiving Cancer Chemotherapy

Cost studies of new drugs approved for clinical use provide valuable information for clinicians who must decide whether to use those drugs for a given patient. This information is especially important when the new and often expensive drug is not directly active against the main disease but may relieve therapy-related side effects. The cost study of Lyman et al. (1) on hematopoietic growth factor (HGF) use in patients receiving cancer chemotherapy is of utmost interest. However, the authors find that "therapeutic HGF always results in a greater cost than no HGF." This statement is based on the assumption that the use of HGFs administered therapeutically (i.e., after onset of neutropenia and fever) in addition to intravenous antibiotics does not result in a reduction in duration of hospitalization or cost. This assumption may not be correct.

To our knowledge, there are no previous reports in the literature on the role of therapeutic HGFs in patients with febrile neutropenia. This situation is somewhat surprising because febrile neutropenia remains a major complication of cancer chemotherapy, and it has been previously stated that minor changes in antibiotic schedule are unlikely to result in major reductions in the mortality rate of febrile neutropenia (2). There is also evidence from animal studies (3) that suggests a role for HGFs in the therapy of neutropenic sepsis.

We have recently completed a randomized trial on the value of adding granulocyte colony-stimulating factor (G-CSF) or granulocyte-macrophage colony-stimulating factor (GM-CSF) to standard antibiotic therapy in the treatment of febrile neutropenia. In this trial, cancer patients with chemotherapy-induced febrile neutropenia (absolute neutrophil count [ANC] <500/μL) were randomly assigned to receive therapy with G-CSF (arm A), GM-CSF (arm B), or placebo (arm C) to be started just after hospital admission. In addition, these patients received intravenous antibiotics. HGFs were discontinued when ANC remained over 1000/μL for 2 consecutive days. Intravenous antibiotics were discontinued and the patients were discharged when they remained afebrile.