

lesions well, and subsequent MRI with pharmacologically induced erection more clearly delineated the lesions and their origin. This demonstrates that even for gross soft tissue lesions of the penis, there can be value added when this technique is employed. We agree with the conclusion of your letter, that MRI with pharmacologically induced erection should be considered in the setting of painful erections.

Competing interests: Authors declare no competing financial or personal interests.

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Correspondence: Dr. Evan Barber, College of Medicine, University of Saskatchewan, Saskatoon, SK; evan.barber@gmail.com

Microscopic hematuria and urothelial malignancy

Sim Sai Tin, MD,*
Viroj Wiwanitkit, MD†

*Medical Center, Shantou, China; †Visiting professor, Hainan Medical University, China

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Kotb and Attia noted that “cystoscopy is highly recommended for young adult men, with significant levels of microscopic hematuria, due to the 20% incidence rate of associated urological malignancy.”¹ In fact, there are several etiologies of microscopic hematuria.² Using cystoscopy might be useful, however, it is questionable due to its invasiveness. There may be some useful additional tests for the differential diagnosis of other causes of hematuria, such as urine biochemistry and urine red cell morphology study. As noted by McDonald and colleagues, the use of urine cytology should be considered before deciding to use cystoscopy to investigate a patient with hematuria.³ A recent medical economics study concluded that “for low-risk patients the use of immediate cystoscopy could be avoided if cystoscopy were used for follow-up patients with a negative initial test using tumour markers and/or cytology.”⁴

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Correspondence: Dr. Sim Sai Tin, Medical Center, Shantou, China; simsaitin@gmail.com

Author response: Microscopic hematuria and urothelial malignancy

Ahmad M. Beltagy, MD; Doaa Attia, MD; Ahmed Fouad Kotb, MD

Urology Department, Faculty of Medicine, Alexandria University, Alexandria, Egypt

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We would like to thank Tin and colleagues¹ for their interest in our publication.² There are many etiologies of microscopic hematuria (MH), other than urinary tract malignancy; however, the presence of dysmorphic red blood cells, proteinuria, casts and/or renal insufficiency or any other clinical indicator suspicious for renal parenchymal disease warrants concurrent nephrologic and urological workup.³

As mentioned in our study,² all patients were initially investigated by urine cytology, which were all negative. Similarly, Feifer and colleagues⁴ found that for patients with MH, voided urine cytology added a significant cost without any diagnostic benefit in the workup for low-risk patients. In their study, it was shown that of 200 patients, 8 (4%) had low-grade urothelial bladder cancer via cystoscopy (Ta or T1 tumours). Of these 8 patients, the cytology was negative in 4 patients and atypical in 4. These cases were asymptomatic contrary to our patients with lower urinary tract symptoms. The economic study referred to by Tin and colleagues was a retrospective study depending on data collection of cases presented in 2003 and 2004 and still confirmed the role of cystoscopy, following negative cytology.

We found that 20% of our cases presented with MH had negative urine cytology, negative findings in multiphasic computed tomography, and positive cystoscopic finding – this number of close to those presenting with gross hematuria. This confirms the importance of cystoscopy as an initial diagnostic tool for high-grade MH.

Competing interests: Authors declare no competing financial or personal interests.

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Correspondence: Dr. Ahmed Fouad Kotb, Department of Urology, Faculty of Medicine, Alexandria University, Alexandria, Egypt; drahmedfali@gmail.com

Scientific evidence dispels false claims about circumcision

Brian J. Morris, DSc, PhD

School of Medical Sciences, University of Sydney, Sydney, Australia

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A recent letter by Robert Darby¹ opposing infant male circumcision (IMC) is not evidence-based, whereas the American Academy of Pediatrics (AAP) 2012 policy supporting IMC is evidence-based.² It concluded that since benefits exceed risks, parents should receive education early in a pregnancy, providers should be trained in safe, sterile technique using local anaesthesia, and access and third party reimbursement should be provided. Not surprisingly, opponents of IMC went on the attack, denouncing the new policy and trotting out their usual array of dubious claims. The knee-jerk reactions by these so-called “child health and human rights experts” have been debunked by the AAP, as well as academic and clinical experts. But Darby ignores the AAP’s response,³ which argued persuasively that claims of “cultural bias” actually applied to the mostly European authors whose paper Darby cites. He also ignores the withering critique⁴ of the article by Svoboda and Van Howe, which he cites.⁵

While IMC does not protect “the neonate, infant or young child” from “HIV and HPV,” the benefits of IMC begin early in life, not just “when the male becomes sexually active.” Benefits include protection

against urinary tract infections,⁶ penile inflammation, inferior hygiene, phimosis, and paraphimosis.^{2,7} Such protections continue through life and in adulthood are supplemented by protection against oncogenic HPVs, genital herpes, some other sexually transmitted infections, candida, penile cancer, prostate cancer,^{2,7} and in women cervical cancer, sexually transmitted infections and bacterial vaginosis.

In contrast to Darby’s claims, the risk of an adverse event from an IMC performed by a competent operator is <0.5%, virtually all of these being easily and immediately treatable with complete resolution.^{2,7,8} His emotive rhetoric about “amputation” (a term reserved for limbs or the entire penis, not the prepuce) and the foreskin being “highly vulnerable to complications and messy cosmetic outcomes,” is extremist and supported by an anti-circumcision book and a 1999 issue of *BJU International* by opponents rather than credible evidence.

The evidence thus flatly contradicts Darby’s statement that “there is no medical justification for circumcision in infancy.” Early infancy is the best time for circumcision. Not only is it safer, simpler, cheaper and more convenient, with optimum cosmetic outcome, but IMC provides immediate lifetime protection, making it akin to vaccination.⁹ Delay means barriers will occur that in older children, adolescence and adulthood reduce the likelihood it will occur, even if the male wishes he were circumcised.⁹

In seeking support for his position, Darby cites a negative IMC policy statement in 2010 by the Royal Australasian College of Physicians (RACP), but fails to reference the devastating critique published in a RACP journal showing why the policy was not evidence-based.⁹

Darby cites his own website in claiming that IMC is in decline in Australia, while not explaining that such statistics apply to Medicare