Problems in the qualitative synthesis paper on sexual outcomes following non-medical male circumcision by Shabanzadeh *et al*

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Shabanzadeh *et al* (1) claim in their title that "*Male circumcision does not result in inferior perceived male sexual function*." Yet such a categorical conclusion does not follow from the data and analysis presented in the paper itself. As the authors state, there was "*considerable clinical heterogeneity in circumcision indications and procedures, study designs, quality and reporting of results*" in the studies they reviewed, which precluded an objective, quantitative assessment. Inadequate follow-up periods of only 1-2 years in the prospective studies imply that their results cannot be generalized beyond that range. In addition, "*Risks of observer and selective reporting bias were present in the included studies … only half of the studies included validated questionnaires and some studies reported only parts of questionnaires*."

There is also a troubling heteronormativity to the authors' headline claim. As they state: "*Most studies focused on the heterosexual practice of intravaginal intercourse and did not take into account other important heterosexual or homosexual practices that comprise male sexual function*." Such practices include, *inter alia*, styles of masturbation that involve manipulation of the foreskin itself, as well as "docking" among men who have sex with men (MSM), both of which are rendered impossible by circumcision (2). Related to this, a recent Canadian study, not included in the paper by Shabanzadeh *et al*, found "*a large preference toward intact partners for anal intercourse, fellatio, and manual stimulation of*

his partner's genitals," in a small but demographically diverse sample of MSM (3).

Against such a backdrop, the authors' characterization of their paper as "*a systematic review*" showing a definitive lack of adverse effects of circumcision on perceived male sexual function is unjustified. As Yavchitz *et al* argue, putting such a conclusive 'spin' on findings that are in truth more mixed or equivocal "*could bias readers' interpretation of [the] results*" (4). Thus, while the literature search performed by Shabanzadeh *et al* may well have been carried out in a systematic manner, their '*qualitative synthesis without meta-analysis'* leaves the distinct impression of a partial (in both senses of the word) assessment.

The authors mention that the rationale for undertaking their analysis was "*the debate on non-medical male circumcision [that has been] gaining momentum during the past few years*". But the public controversy surrounding male circumcision has to do with the performance of surgery on underage boys, specifically, in the absence of medical necessity. By contrast, therapeutic circumcisions that cannot be deferred until an age of individual consent are broadly perceived to be ethically uncontroversial, as are voluntary circumcisions performed for whatever reason on adult men, who are free to make such decisions about their own genitals (5). Consequently, studies dealing with either therapeutic or adult circumcisions are irrelevant to the ongoing controversy and should have been excluded by the authors in light of their own aims; such exclusion would have left only a handful of relevant investigations out of the 38 included studies.

As one of us has noted elsewhere: "*the [sexual] effects of adult circumcision, whatever they are, cannot be simply mapped on to neonates*" or young children (2). This is because studies assessing sexual outcome variables in adults typically do not account for socially desirable responding (6); they concern men who, by definition, actively desire to undergo the surgery to achieve a perceived benefit, and are therefore likely to be psychologically motivated to regard the result as an improvement overall; and such studies are typically hampered by limited follow-up (as noted above), rarely if ever extending into older age, when sexual problems begin to increase markedly (7). In infant or early childhood circumcision, by contrast, "*the unprotected head of the penis has to rub against clothing*

(etc.) for over a decade before sexual debut. In this latter case … the affected individual has no point of comparison by which to assess his sexual sensation or satisfaction - his foreskin was removed before he could acquire the relevant frame of reference - and thus he will be unable to record any differences" (2).

The sexual consequences of circumcision are likely to vary from person to person. All-encompassing statements, such as that forming the title of the paper by Shabanzadeh *et al*, do not reflect this lived reality. Individual differences in sexual outcome variables will be shaped by numerous factors, such as the unique penile anatomy of each male, the type of circumcision and the timing of the procedure, the motivation behind it, the cultural context, whether it was undertaken voluntarily (or otherwise), the man's subjective feelings about having been circumcised, his underlying psychological profile, and so on (8, 9). Collapsing across all of these factors to draw general conclusions can only serve to obscure such crucial variance (10).

Therefore, the choice of the authors to include any study looking at sexual outcomes after circumcision, whether in boys or adult males, whether in healthy individuals or in patients with a foreskin problem, whether in Africa or in Western settings, and whether with a follow-up period of decades or only a few months to years is problematic. Such a cacophony of 38 studies, dominated by findings on short-term sexual consequences of voluntary, adult male circumcision has limited relevance, if any, to the authors' stated research question: how non-therapeutic circumcision in boys affects the sex lives of the adult men they will one day become.

References

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