Phimosis

EPIDEMIOLOGY, AETIOLOGY:
At the end of the first year of life, retraction of the foreskin is possible in approximately 50% of boys. This increases to approximately 89% by the age of 3 years. The incidence of phimosis is 8% in 6 to 7 year olds and 1% in males aged 16 to 18 years.

Phimosis is either primary with no sign of scarring, or secondary (pathological) due to scarring such as balanitis xerotica obliterans (BXO).

DIAGNOSTIC EVALUATION:
The diagnosis of phimosis and paraphimosis is made by physical examination: prepuce is not retractable, or only partly retractable, and shows a constrictive ring on drawing back over the glans penis.

Paraphimosis is characterised by a retracted foreskin with the constrictive ring localised at the level of the sulcus, which prevents replacement of the foreskin over the glans. Must be regarded as an emergency situation.

MANAGEMENT:
Forceful preputial retraction should be discouraged to avoid cicatrix formation.

A corticoid ointment or cream (0.05-0.1%) can be administered twice a day over a period of 4-8 weeks. This treatment has neglectable side effects and the mean blood cortisol levels are not significantly altered.

Plastic circumcision has the objective of achieving a wide foreskin circumference with full retractability, while the foreskin is preserved. This procedure carries the potential for recurrence.

Absolute indications for circumcision: secondary phimosis, recurrent balanoposthitis and urinary tract infections. Simple ballooning of the foreskin during micturition is not a strict indication.

Undescended testes/ cryptorchidism

EPIDEMIOLOGY, BACKGROUND:
Incidence varies on gestational age, affecting 1-4.6% of full-term and 1.1-45% of preterm neonates. Nearly 1% of all full-term male infants still have undescended testes at one year.

May affect both sides in up to 30% of cases. In these cases and if any sign of disorders of sex development is present, urgent endocrinological and genetic evaluation is required.

CLASSIFICATION:

MANAGEMENT:

A non-palpable testis needs to be confirmed under general anaesthesia, as this is the first step of any surgical procedure.

History taking and physical examination are key in diagnosis. Localisation imaging studies are usually without additional benefit.