We write to express our comments on the article which was published in this journal of Translational Andrology and Urology by Kwok et al. entitled “Prevalence and sequelae of penile lichen sclerosus in males presenting for circumcision in regional Australia: a multicenter retrospective cohort study” (1). The authors raised a very important topic concerning the incidence of lichen sclerosus (LS) in foreskins obtained during circumcision at 8 hospitals.

Penile LS is a chronic and fibrotic dermatosis which often occurs on the prepuce and glans of the penis. Etiopathogenesis is unknown, but nowadays authors are more likely to suggest that occlusion and irritating effects of urine could be the main reason for LS formation (2-4). Moreover, microdribbling incontinence in occlusion conditions could provide to higher gene expression of proinflammatory cytokines such as interleukin 1-A (IL-1A), interleukin 6 (IL-6) and interferon-gamma (INF-γ) which may confirm this hypothesis (2).

Circumcision is curative in nearly 100% of cases of penile LS. Additionally, in phimosis (common LS complication) male circumcision not only relieves subjective symptoms of phimosis (as LS complication) but improves the quality of sexual life (5).

In the literature, there is a large discrepancy from 1% to 67.4% in the prevalence of LS in foreskins obtained during circumcision (6,7). For this reason, research on that subject is needed.

However, we have some questions and comments to the article entitled “Prevalence and sequelae of penile LS in males presenting for circumcision in regional Australia: a multicenter retrospective cohort study” (1). The first question is: what is the real indication of circumcision in this study? The authors of the article mentioned that circumcision was generally undertaken in those presenting with symptomatic penile pathologies such as phimosis or penile infections. However, in the next paragraph authors pointed out that specimens are commonly referred for pathological analysis only when there is clinical concern for significant underlying abnormality. What do the authors understand by penile abnormality? Do they suggest that phimosis or penile inflammation are not abnormalities? Reliance only on clinical symptoms could provide bias because clinical diagnosis is not always accurate with histopathological examination. According to the data from the literature, the precision of clinical diagnosis (performed separately by urologist and dermatologist) in the case of phimosis was estimated only to be 67% (7).

The second reservation is percent of foreskin specimens sent for pathological examination. For example, in the same region, Toowoomba in public hospitals only 24% (40/164) of specimens were sent for pathological examination, on the other hand in St Andrew’s and St Vincent’s Private Hospital Toowoomba was 100% (150/150). We wonder if the authors see such discrepancy. In our opinion, the research would be more transparent if the authors include only the hospitals where percent of foreskins sent for analysis was 100% [St Andrew’s and St Vincent’s Private Hospital Toowoomba was 100% (150/150); Mater Mackay Hospital was 100% (19/19)].
Finally, in the title, Tab. 1 and conclusion the high prevalence of LS (63.6%) was in foreskins analyzed by pathomorphologist but not in the patient presenting for circumcision, since only 313 (51.2%) from 611 foreskin specimens were sent to the pathologist.

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Footnote

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