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LETTER TO THE EDITOR

Letter to the Editor regarding 'Histopathological assessment practices in adult male circumcision and detection of lichen sclerosus: a retrospective single-centre study'

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Dear Editor,

I read with great interest the article by Engman et al. [1], which addresses the important and often overlooked issue of histopathological assessment following medical circumcision and the detection of lichen sclerosus (LS). The study benefits from a relatively large cohort of 416 patients and provides valuable data on real-world clinical practice over an 8-year period. However, I believe that several methodological considerations warrant discussion, as they have significant implications for the interpretation of the study's central conclusions regarding underdiagnosis and undertreatment of LS.

My primary concern relates to the assertion that only 15% of patients with histopathologically confirmed LS received appropriate post-operative management, which the authors interpret as evidence of severe undertreatment. This conclusion, however, overlooks a fundamental clinical distinction. Penile LS can be confined to the prepuce or extend to involve the glans penis and urethral meatus [2, 3]. When LS is limited to the prepuce, circumcision alone may be curative, and additional topical corticosteroid therapy or dermatological referral is not necessarily indicated [4, 5]. The study provides no data on the extent of disease beyond the excised tissue. Without systematic documentation of glans and meatal involvement, it is not possible to determine how many of the remaining 85% of patients genuinely required further treatment versus those in whom circumcision constituted definitive management. Attributing undertreatment to clinicians without this essential clinical context risks mischaracterising what may, in many cases, represent appropriate surgical care.

Secondly, the authors report that LS was identified in 60% of histopathologically examined specimens and suggest that LS is substantially underdiagnosed in the broader circumcision population. However, their own regression analysis demonstrates that submission for histopathological analysis was not random but was driven by clinical suspicion: the presence of white lesions (Odds Ratio (OR) 2.97), atypical skin lesions (OR 5.16), severe phimosis, and older age were all significant predictors. This constitutes a classic verification bias [6]. While I acknowledge that the documentation and diagnostic coding of confirmed LS cases was indeed deficient – only 13% received a recorded diagnosis – the extrapolation that a comparable rate of LS exists among the 56% of patients whose specimens were not examined is unsupported. The true prevalence of LS in the unselected circumcision population remains unknown and is likely considerably lower than 60%.

Thirdly, the authors' approach to missing data introduces a systematic information bias. The absence of documentation of clinical findings (e.g. fissures, white lesions) was interpreted as the absence of the finding itself. In a busy clinical setting, negative findings are inconsistently recorded, and their absence in the chart does not equate to their absence on examination [7]. This assumption may have led to an underestimation of pre-operative clinical signs suggestive of LS, thereby artificially inflating the proportion of cases deemed 'clinically missed' and reinforcing the underdiagnosis narrative. No sensitivity analysis was performed to assess the impact of this assumption on the reported results. Moreover, as a single-centre retrospective study, post-operative treatment and referrals occurring outside Umeå University Hospital – such as in primary care or other dermatology clinics – would not have been captured, further compounding the risk of underestimating the proportion of patients who received appropriate follow-up care.

I fully agree with the authors' recommendation that all circumcised preputial tissue should be submitted for histopathological examination to ensure accurate diagnosis and to detect potential dysplastic changes [4, 8]. However, the interpretation of histopathological findings must be

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contextualised within the clinical picture. Future prospective studies should systematically assess glans and meatal involvement, document post-operative disease activity, and capture follow-up across healthcare settings to provide a more accurate evaluation of LS management after circumcision.

Disclosure of interest

The author reports no conflicts of interest.

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Reply to Letter to the Editor regarding 'Histopathological assessment practices in adult male circumcision and detection of lichen sclerosus: a retrospective single-centre study

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Dear Editor,

We thank you for the opportunity to respond to the Letter to the Editor regarding our article, "Histopathological assessment practices in adult male circumcision and detection of lichen sclerosus: a retrospective single-centre study." We are grateful to the author for the careful reading of our work and for raising several relevant methodological and clinical considerations.

Regarding the concern that our interpretation of post-operative management may overstate "undertreatment," we agree that this issue requires clinical nuance. As noted in the Letter to the Editor, lichen sclerosus (LS) may in some patients be confined to the prepuce, and circumcision alone may therefore be sufficient treatment. However, current recommendations suggest a course of pre- and postoperative treatment with topical corticosteroids in circumcised LS patients, which we aimed to highlight [1]. As our retrospective data did not allow systematic assessment of glans or meatal involvement, nor post-operative disease activity, we acknowledge that this limits conclusions about the need for further treatment. As discussed in the manuscript, there is limited evidence regarding long-term outcomes following circumcision in LS patients, and the extent to which surgery alone is curative remains uncertain. Prospective studies are needed to determine to what extent surgical intervention alone can be considered curative and to better define optimal post-operative management strategies [2]. Importantly, our findings regarding low rates of diagnostic coding and documented follow-up after histopathological confirmation are independent of disease extent and remain clinically relevant. We also agree regarding verification bias. Histopathology in our study was performed selectively and associated with clinical suspicion, as shown in our regression analysis. As already stated in the Discussion, this precludes interpretation of the observed proportion as an unbiased prevalence estimate. Our intention was not to estimate true prevalence, but to describe histopathologically confirmed LS among submitted specimens and highlight gaps in clinical detection and documentation in routine practice.

Concerning missing or undocumented data, we recognise the inherent risk of information bias in retrospective designs. This limitation was addressed in the Discussion. Absence of documentation was interpreted as absence for routinely recorded variables, while symptom-related variables were interpreted as reported symptoms. We acknowledge that some pre-operative findings may have been under-recorded. We also acknowledge that post-operative management outside the records of Umeå University Hospital may not have been fully captured. As a single-centre study, our data are limited in this respect. Although external referrals were investigated, follow-up initiated by patients themselves may not have been recorded. Nevertheless, we believe that the core findings of the study remain valid and clinically relevant. As highlighted in the manuscript, histopathological examination of circumcised tissue was not routinely performed, yet LS was identified in a substantial proportion of analysed specimens. In parallel, only a minority of histopathologically confirmed cases had documented diagnosis or follow-up. These findings support routine histopathological assessment to improve case detection, as well as better diagnostic documentation and structured follow-up.

We agree that prospective studies should systematically assess disease involvement, including pre- and post-operative disease activity and treatment, as well as follow-up across healthcare settings to better determine when circumcision alone is sufficient.

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