opposite side, and the remaining 4 cc distributed around this half of the penile circumference. The skin of the penis is so loose that a single skin puncture with a 1-inch long needle can reach all around. Do not penetrate the fascia, but remain in the very loose subcutaneous layer. One can then grasp the edge of the foreskin with a mosquito clamp to verify anesthesia.

For a newborn, 1 mL of 1 percent lidocaine suffices. After clamping the edge of the foreskin, a blunt probe is used to free its adhesions to the glans. The cup of the Gomco clamp is inserted, then the base of the clamp. The foreskin is pulled through the gap, taking as much mucosa as possible and relatively less skin. Most Gomco clamps do not tighten adequately, but by inserting a scalpel handle under the fulcrum, one can tighten it so that the severed edges are crushed together and do not separate after the clamp is removed. A strip of Vaseline™ gauze then surrounds the severed edge. With adult circumcision, however, it is necessary to suture all around the cut circumference of the foreskin, or it will later separate, retract, and bleed when an erection occurs.

I have found this circumferential nerve block 100 percent effective.

Sam I. Lerman, M.D.
Canton, MI

References

1. Toffler WL, Sinclair AE, White KA. Dorsal penile nerve block during newborn circumcision: underutilization of a proven technique. J Am Board Fam Pract 1990; 3:171-4.

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: Dr. Lerman is clearly "ahead of his time" in reporting his use of local anesthesia with circumcision almost two decades before Kirya and Werthmann first described their technique in 1978.[1] Dr. Lerman's experience calls attention to the need for family physicians to report innovative practice techniques and to avoid keeping their "light under a bushel." His use of this technique in adults is quite appropriate and can avoid the need for spinal or general anesthesia. Dr. Lerman's letter emphasizes the importance of procedural details to enhance the likelihood of achieving effective anesthesia and adds support to our belief that further educational efforts are needed to increase the awareness and appropriate use of a local anesthetic in performing circumcisions in the newborn.[2]

Although a subcutaneous infiltration is one approach to achieving anesthesia of the penis, dorsal penile nerve block achieves the same effect by discretely blocking the dorsal nerves innervating the penis and does not require circumferential infiltration at the base of the penis. A more detailed description of the technique of dorsal penile nerve block is forthcoming.[3]

William L. Toffler, M.D.
Ann Sinclair, M.S.
Keith White, M.D.
Portland, OR

References

1. Kirya C, Werthmann MW Jr. Neonatal circumcision and penile dorsal nerve block – a painless procedure. J Ped 1978; 96:998-1000.
2. Toffler WL, Sinclair AE, White KA. Dorsal penile nerve block during newborn circumcision: underutilization of a proven technique? J Am Board Fam Pract 1990; 3:171-4.
3. Fontaine P, Toffler WL. Dorsal penile nerve block for newborn circumcision. Am Fam Physician (accepted for publication).

Infectious Vaginitis

To the Editor: In his recent review "Diagnosis and Management of Infectious Vaginitis" (J Am Board Fam Pract 1990; 3:195-205), Dr. Quan suggests that "Bacterial Vaginosis" is the most appropriate term for nonspecific vaginitis secondary to bacterial overgrowth. A careful review of the use of the suffix "-osis" would suggest, however, that the most appropriate term for this clinical entity would be "Vaginal Bacteriosis."

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