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22. Sara CA, Lowry CJ. A complication of circumcision and dorsal nerve block of the penis. Anaesth Intensive Care 1985; 13:79-82.

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

To the Editor: We commend Ganiats and Schmidt for their detailed MEDLINE literature review. At the same time, some of the findings drawn from their own review of the existing literature seem inconsistent with their conclusions. For example, they describe a "paucity of research" and then reference 19 "appropriate research articles." They conclude that "one large-scale study . . . appears to underreport complications," yet fail to state the basis for this conclusion. They also conclude that the lack of widespread acceptance of dorsal penile nerve block reflects a lack of safety data, yet only 27 percent of the doctors we surveyed stated that they were not using the technique because of a "concern of risk." [1]

The report of two cases of gangrene following dorsal penile nerve block in infants deserves clarification. The technique used was distinctly different from that first described by Kirya and Werthmann and also utilized bupivacaine as the local anesthetic.[2,3] Despite the apparently complete MEDLINE review with 22 references, the authors have excluded work by Stang and Snellman, who reported their experience with dorsal penile nerve block in more than 2000 circumcisions without any clinically significant complications.[4] Ganiats and Schmidt's concern about the potential for future impotence seems unlikely with the clinical observation of postcircumcision erections in babies, whether dorsal penile nerve block is employed or whether it is not. In short, the conclusion that dorsal penile nerve block "has not yet been proved safe" seems inconsistent with the very data that they present, just as it is inconsistent with our own experience.

Additionally, although not impossible, it seems improbable that after 12 years of using this technique nationally, other complications have not surfaced. A conservative estimate of the number of procedures done to date would number in the hundreds of thousands or more. In addition, the procedure has been performed for even longer by anesthesiologists for postoperative anesthesia for circumcision in older persons.

Nevertheless, we agree that further research involving long-term effects is worthwhile to reassure physicians who have persistent serious concerns about possible long-term consequences. In fact, such studies are underway by at least two separate investigators in Minnesota (personal communication). Meanwhile, the procedure clearly decreases the pain associated with circumcision in infants, positively affects the behavior following the procedure, and clearly assuages the guilt that many parents feel when they decide to have their children circumcised and consider the pain that would otherwise result from the procedure.

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Infectious Vaginitis

To the Editor: In the article entitled "Diagnosis and Management of Infectious Vaginitis," [1] Dr. Quan states, "Controversy continues to exist whether the man consort(s) of the patient with bacterial vaginosis requires simultaneous treatment." [p 203] Dr. Quan cites our study and correctly indicates that we concluded that treatment of the male partner produces a short-term reduction in recurrence rates. He then references three other reports, which he states were studies that did not report a benefit from male sexual partner treatment.[3-5] Unfortunately, of the three references that Dr. Quan cites, one is a review article that simply says that male sexual partner treatment has not been shown to be effective, and the authors do not provide references.[3] Another is a dose-duration study of metronidazole treatment in patients with bacterial vaginosis, and no data are described about male sexual partner treatment. The other reference, even though it is to a study that examines the issue of male sexual partner treatment, lacks adequate statistical power to conclude that male sexual partner treatment does indeed make no difference in cure rates or recurrence rates.[4,6] Although it seems from Dr. Quan's article that there is only one study that supports the effectiveness of male sexual partner treatment in women with bacterial vaginosis and three against, this is clearly not the case. We believe this is an inaccurate portrayal of this controversial area.

It is controversial because investigators do not enroll enough women in their studies to insure adequate statistical power to find a clinically significant difference in cure rates or recurrence rates, should it indeed exist. We think that clinicians would pay attention to a 20 percent difference in cure rates between a group in which the male sexual partner was treated versus not treated[7] and have calculated the number needed in each group at various statistical powers, from a minimal power of 0.80 to a maximal power of 0.95, using a baseline cure rate of 90 percent, which is the baseline cure rate found in most studies if the woman is treated with a 7-day course of