What is the best initial treatment for phimosis?

Evidence-Based Answer

When treatment is necessary for phimosis, application of topical steroid seems to be an effective first-line treatment. (SOR **B**, based on a high-quality randomized control trial.)

Phimosis refers to difficulty retracting the prepuce secondary to a tight distal preputial ring. While relatively common at birth, this condition normally resolves spontaneously by 3 to 4 years of age. Over time, phimosis can lead to chronic inflammation, dyspareunia, or even penile carcinoma. Surgical treatment is often performed on boys suffering from persistent phimosis, but the procedure carries the risk of postoperative complications. Conservative treatment with topical steroids is a nonsurgical option.

In 2002, a prospective, randomized double-blind study examined 137 boys (aged 3–15 years) randomly assigned to receive either topical 0.1% betamethasone cream or placebo (aqueous cream) for 4 weeks. Patients were instructed to apply the cream twice daily, after retracting the prepuce as much as possible without causing harm and pain. After the 4-week assessment, all nonresponders in both groups were offered a course of steroid cream.

The first follow-up cure rate with steroid cream was 74% compared with 44% in the placebo group (number needed to treat=3; $P<.01$). The overall cure rate was 86% by 18 months.[1]

An unblinded, prospective cohort study enrolled 247 boys (treatment group) and 90 boys (placebo group) aged 4 to 14 years. In the treatment group, patients received 0.05% betamethasone cream applied twice daily for the first 15 days, then once daily for 15 more days. Preputial stretching started 1 week after topical application. A control group used preputial stretching only. Follow-up examinations were carried out at 10 days after the end of each 30-day treatment cycle. If initially unsuccessful, the treatment cycle could be repeated up to a total of 3 times.

Treatment with steroid creams plus stretching was successful in 96% of patients compared with 76% with stretching alone ($P<.001$) after a maximum of 3 cycles. These results were maintained at 3- and 6-month follow-up visits.[2]

A case series reported on the progress of 194 boys (aged 1–16 years) with phimosis. A 6-week course of 0.1% betamethasone ointment was applied twice daily for 6 weeks. Patients were reexamined by the consultant urologist at 3 months after initiation of treatment. In this series, 87% of patients with phimosis treated with topical steroid were able to retract the foreskin appropriately after treatment.[3]

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What therapies are effective for relief of chronic vertigo symptoms?

Evidence-Based Answer

It depends on the cause of the vertigo. For unilateral peripheral vestibular dysfunction, vestibular rehabilitation (VR) improves subjective dizziness. In benign paroxysmal positional vertigo (BPPV), canalith repositioning maneuvers are associated with excellent short-term relief. (SOR **A**, based on a systematic review.) In patients with Ménière's disease, instruction in VR and symptom control are equally effective; the Meniett device can produce symptom relief in refractory cases. (SOR **B**, based on randomized controlled trials [RCTs].) Antihistamines, anticholinergics, benzodiazepines, diuretics, calcium channel blockers, and topiramate may also help relieve symptoms. (SOR **C**, based on expert opinion.)

Twenty-one RCTs including 1,383 adults with unilateral peripheral vestibular dysfunction were analyzed in a Cochrane review. Of those, 10 trials compared VR with control (placebo, no treatment, sham, or usual care). Four of the 10 studies had subjective improvement in dizziness as an outcome measure. All 4 studies showed VR is associated with subjective improvement in dizziness (136/278 patients in treatment groups reported