Circumcision practice in the Philippines: community based study

Male circumcision is a well studied phenomenon. However, much of the published knowledge on circumcision is derived from highly industrialised Western countries, particularly the United States. The non-Western context of circumcision is not well known despite being a universal practice in various countries. For example, in the Philippines, circumcision was common in the past as it is at present, being an integral aspect of the social organisation of the society. This report offers a Philippine perspective of male circumcision, particularly its adoption and complications. The study employed semi-structured face to face interviews with 114 circumcised males conveniently recruited using a snowball technique from two communities. One fifth (22) of the clients were aged 13–18, while the rest were older, working in varied and low income occupations, and were single, married, or separated.

The majority of respondents (51.7%) were circumcised between ages 10 and 14. Others had the same experience before age 10 (42.1%) or between 15 and 18 (5.3%). Respondents gave several reasons for their circumcision: not wanting to be called "supot" or uncircumcised (66.7%); being at the right age (41.2%); and wanting to grow tall and physically fit (29.8%). Other reasons included the need to get rid of smegma in the penis (22.8%); to cause pregnancy (20.2%); and to obey parents (18.4%) (table 1). Seven of every 10 clients (68.4%) were circumcised by doctors and lay people in the community. The central role of lay individuals in undertaking circumcision is part of the traditional character of this community based practice.

Post-circumcision complications were limited to inflammation and swelling, consistent with Western data wherein risks are regarded as minor and complications were at a rate 0.2 to 0.6%. Respondents did not take these complications nor the risks from circumcision seriously when they opted not to see their circumcisers and when they adopted self medication. The seeming lack of serious concern for these problems was inappropriate given that the healing period of the circumcised penis of many respondents was highly protracted. Much of the foregoing evidence on reasons for adopting circumcision highlights the fact that respondents' circumcision was predominantly traditional.

Acknowledgements

The reported research was funded by a grant from the Ford Foundation/Jakarta through the Australian National University Demography Department (S440125). I thank the team members—Loyd Norella, Bruce Ragas, Redentor Rola, Michael Sibulana and Christian Tena—for their research assistance.

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Accepted for publication 13 March 2004

Table 1 Clients' reasons why they underwent circumcision

<table>
<thead>
<tr>
<th>Responses</th>
<th>No</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To avoid being called &quot;supot&quot; or uncircumcised</td>
<td>76</td>
<td>66.7</td>
</tr>
<tr>
<td>2. Already a grown up, of the right age—part of the tradition to undergo circumcision</td>
<td>47</td>
<td>41.2</td>
</tr>
<tr>
<td>3. To grow tall and physically fit</td>
<td>34</td>
<td>29.8</td>
</tr>
<tr>
<td>4. Wanted his penis to be free of smegma</td>
<td>26</td>
<td>22.8</td>
</tr>
<tr>
<td>5. To be able to cause pregnancy; wanted to have a child of his own</td>
<td>23</td>
<td>20.2</td>
</tr>
<tr>
<td>6. Parents told him to undergo the procedure</td>
<td>21</td>
<td>18.4</td>
</tr>
<tr>
<td>7. To court a girl, have a girlfriend and get married</td>
<td>14</td>
<td>12.3</td>
</tr>
<tr>
<td>8. Women like to have sexual intercourse with a man whose penis is circumcised</td>
<td>12</td>
<td>10.5</td>
</tr>
<tr>
<td>9. To facilitate entry of his penis during sexual intercourse</td>
<td>7</td>
<td>6.1</td>
</tr>
<tr>
<td>10. To enhance the form of his penis and to make his glans larger</td>
<td>7</td>
<td>6.1</td>
</tr>
<tr>
<td>11. It is in the Bible that a Christian must be circumcised</td>
<td>4</td>
<td>3.5</td>
</tr>
<tr>
<td>12. To become intelligent</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>13. Circumcision was free</td>
<td>2</td>
<td>1.8</td>
</tr>
</tbody>
</table>

*Multiple response (n = 114)

References


Repeated detection of lymphogranuloma venereum caused by Chlamydia trachomatis L2 in homosexual men in Hamburg

Bacteria of the species Chlamydia trachomatis are divided into serovars that are associated with different disease manifestations. Serovars A-C cause trachoma, which occurs mainly in undeveloped countries. Serovars D-K are responsible for ocugenital infections, and serovars L1, L2, and L3 cause lymphogranuloma venereum (LGV). Infections of serovars A-K are usually confined to the mucosal epithelia of the eyes and the anogenital tract. In contrast, the L-serovars are more invasive and may induce genital ulcer or inguinal lymphadenopathy after passing the epithelial surface.

While serovars D-K are distributed worldwide and represent the most frequent bacterial sexually transmitted disease in Europe and North America, LGV caused by the L-serovars is a very rare disease in industrialised countries, but is restricted to parts of southeast Asia, Africa, South America, and the Caribbean.

During the second part of 2003 three patients were presented to our clinic with inguinal swellings. In addition, genital ulcer developed in two of them. All patients had homosexual contacts with more than one partner. Two patients were HIV positive, one of them refused HIV testing. The patients assured us that they had not travelled outside Germany during the past year.

In all cases genital C trachomatis infection was diagnosed by DNA amplification in lesion swabs or lymph node aspirates using the SDA technology (ProbeTec ET, Becton-Dickinson, MD). Other infections inducing genital lesions were not detected. None of the patients had a positive serology indicating active infection with Treponema pallidum. Genital infections due to Neisseria gonorrhoeae, Haemophilus ducreyi, and herpes simplex virus were excluded by polymerase chain reaction (PCR) testing. In addition, no genital bacterial and fungal pathogens were detectable by direct microscopy or culture.

After treatment with doxycycline (200 mg per day), genital lesions completely regressed in all patients. Patients 2 and 3 were treated.
Determinants of hospital mortality of HIV infected patients from north India

A majority of the HIV infected population lives in developing nations. Most patients require hospitalisation for management of opportunistic infections (OIs) sometime during the course of their illness. Locally endemic infections and underlying malnutrition tend to influence the manifestations and course of the disease.1 However, there is paucity of data on pattern of disease and determinants of immediate outcome of such patients from Indian subcontinent.2

We report the determinants of hospital mortality in a cohort of 135 consecutive cases of HIV/AIDS, aged 13 years and above, admitted to the All India Institute of Medical Sciences (AIIMS), New Delhi, during the period of January 2000 through July 2003. These patients had been hospitalised for suspected OIs, and all patients underwent examination for diagnosis with subsequent management as per standard guidelines. For patients with Pneumocystis jiroveci pneumonia (PCP) whenever hypoxaemia was severe (PaO2<70 mm Hg; n = 5), corticosteroids were given in addition to oral co-trimoxazole.

None of these patients received assisted ventilation. Secondary prophylaxis for the OIs was initiated as recommended.3

Mean age of the patients was 34 (SD 10) years and 23 patients (17%) were women. CD4+ cell counts were done in 109 patients. Most of these patients (82.6%) had CD4+ cell counts less than 200 cells x10^3/l. Fifty patients (46%) had CD4+ cell counts less than 50 cells x10^3/l. The mean number of OI was 1.4 per patient. The commonest OI was tuberculosis (TB) (71.1%), followed by oral candidiasis (39.3%). Other OIs (full data presented elsewhere) included PCP (n = 10), cryptococcal meningitis (n = 8), cerebral toxoplasmosis (n = 5), cytomegalovirus retinitis (n = 3), visceral leishmaniasis (n = 2), and progressive multifocal leukoencephalopathy (n = 1).

Twenty one patients (15.6%) died in hospital, most of them as a result of TB (n = 16; 76.2%) and PCP (n = 4; 19%). Factors associated with hospital mortality, on bivariate analysis, are shown in table 1. After adjusting for other factors (by multivariate logistic regression analysis), PCP was the only independent determinant and was associated with a more than fourfold increased risk of hospital mortality (adjusted odds ratio (95% CI): 4.7 (1.1 to 20.9); p = 0.041).

Overall hospital mortality of 15.6% in this cohort is considerable and reflects the advanced nature of the disease at presentation. As our institute is a tertiary care facility for patients with Pneumocystis jiroveci pneumonia, we were able to institute effective treatment and also to institute secondary prophylaxis to avoid opportunistic infections that may otherwise have contributed to the higher hospital mortality rates.

Methodology

The study was prospective and a hospital based cohort study. All HIV infected patients, aged 13 years and above, admitted to the All India Institute of Medical Sciences (AIIMS), New Delhi, admitted since the period of January 2000 through July 2003, were included in the study. The patients were assessed for prevalence of OIs on admission and during the course of treatment. The OIs were diagnosed and managed as described by the Infectious Diseases and Medical Microbiology section of the hospital.

The patients were assessed for the presence of OIs on admission and followed up until discharge or death. The diagnosis of OIs was based on the criteria described by the Centers for Disease Control and Prevention (CDC) for surveillance.4 The treatment of OIs was according to the centre for the disease control and prevention guidelines.5

The data were entered into Microsoft Excel, and the analysis was done by Statistical Package for Social Sciences (SPSS) version 11.5. Descriptive statistics, frequency analysis, and chi-square test were used to identify independent determinants of in-hospital mortality. A p value of 0.05 or less was considered to be statistically significant.

Table 1: Predictors of in-hospital mortality in 135 HIV infected patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Survived (n = 114)</th>
<th>Died (n = 21)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE score*</td>
<td>30 (23–30)</td>
<td>5 (0–30)</td>
<td>0.001</td>
</tr>
<tr>
<td>Blood urea (mg/dl)</td>
<td>29 (16)</td>
<td>41 (35)</td>
<td>0.051</td>
</tr>
<tr>
<td>CD4+ count x10^3/l</td>
<td>62 (9–152)</td>
<td>38 (7–111)</td>
<td>0.029</td>
</tr>
<tr>
<td>Pericardial effusion</td>
<td>0.8%</td>
<td>9.2%</td>
<td>0.051</td>
</tr>
<tr>
<td>ATT</td>
<td>63%</td>
<td>80%</td>
<td>0.033</td>
</tr>
<tr>
<td>PCP</td>
<td>5.3%</td>
<td>19%</td>
<td>0.004</td>
</tr>
</tbody>
</table>

MMSE, Mini Mental Status Examination; ATT, antiretroviral treatment; PCP, Pneumocystis jiroveci pneumonia.

*Data are presented as median (interquartile range); p values determined by Mann-Whitney U test.
†Data are presented as mean (SD); p value determined by independent t test.
‡Data are expressed as proportion; p values determined by chi^2 test.
and a national referral centre, this is expected. None the less, it may be possible that some OIs remained undiagnosed and indirectly affected the outcome. This does occur as was shown in a necropsy study where it was found that a large number of potentially fatal OIs were not diagnosed antemortem. Unexpectedly, CD4+ counts had no independent effect on mortality. A similar observation has been reported in some previous studies. It appears that the virulence of the pathogen causing the OI, rather than the stage of the underlying disease, tends to influence the short term outcome. This finding has important therapeutic implications, especially because almost all these patients die of an OI.

It is suggested that any HIV infected patients with an OI, irrespective of the stage of the disease, should be managed with an aggressive approach. Once they recover from the OI, they can be offered antiretroviral therapy, which, over the years, has become extremely potent and effective. Such an approach is likely to improve the long term outcome of these patients.

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doi: 10.1136/sti.2004.009241
Accepted for publication 18 March 2004

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STI services in the United Kingdom, how shall we cope?
The recent proposals/debate addressing the increasing genitourinary medicine (GUM) workload are imaginative. I wish to contribute the following observations:

(1) The listed “guiding principles” for the GUM services role are missing the most important function that is expected by patients: to exclude sexually transmitted infections. Casual sex, contact tracing, and sexual assault are examples of conditions that require full assessment.

(2) The revelation that some 9% of the sexually active population are harbouring asymptomatic chlamydial infection presents GUM physicians with a professional responsibility. Chlamydia screening will require extensive resources and primary care.

(3) The debate ignores the issue of funding. To assume that GPs are going to provide “additional services” for a lower cost than GUM clinics, with their existing infrastructure, contradicts the basis of health care economics.

(4) The relation between quantity and quality of health care is inverse; with both healthcare workers and clients appreciative of this relation. The pressures for quantity will eventually force the quality of care downhill.

(5) Clinical governance implicates clinicians (as providers and stakeholders) in the quality of their provision. It would be professionally unwise to compromise on quality as a result of the static, or a relative decrease in, funding. It is professionally unacceptable and could prove medicolegally indefensible.

(6) The open access of the GUM clinics will always attract patients, and the free prescriptions will continue to influence demand (particularly with recurrent infections).

(7) There is a potential of primary care’s initial enthusiasm to fade away, with patients re-diverted to GUM clinics, while resources are tracking in the other direction. It would be professionally unwise to compromise on quality as a result of the static, or a relative decrease in, funding. It is professionally unacceptable and could prove medicolegally indefensible.

I propose the following alternative models of service:

(1) “Three tiered” GUM services are provided, within existing GUM departments, where care is streamlined with defined “clinical care pathways”:

(a) The first tier/setting of service could be provided by nurses and/or junior doctors (under the supervision and support of senior GUM physicians). It will triage patients and deal with primary care conditions.

(b) The secondary tier/setting would deal with clinical conditions of intermediate complexity (that prove to be outside the expertise of the first setting). It will be provided by medical staff, of intermediate seniority, supported by senior/specialised nurses.

(c) The tertiary tier/setting is already existing within most GUM services for example, HIV, sexual dysfunction, genital dermatosis, forensic gynaecological medicine). It will be provided by specialised medical staff, assisted by specialised nurses, where junior grades attend for training.

(2) A “three sessions” day could be provided, to maximise the use of accommodation and infrastructure resources. Evening and/or weekend clinics to be considered—with appropriate funding.

(3) The proposal of satellite GUM clinics where local services are unable to cope with demands. They could be provided (and supported) by existing larger primary care, GPs and/or family planning units, under the auspices of the main GUM clinic. This will maintain and ensure quality, KC60 reporting, confidentiality, and/or free prescribing.

These modules are already taking shape in some GUM departments.

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doi: 10.1136/sti.2004.009829
Accepted for publication 19 March 2004

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Refrigeration does not compromise recovery of Neisseria gonorrhoeae from charcoal transport swabs
Despite emergent molecular diagnostics, culture recovery of Neisseria gonorrhoeae (NG) remains important for the diagnosis of gonorrhoea, as well as for susceptibility and epidemiological study. Although inoculation of bacteriological media in clinic is optimal, it can prove impractical, or impossible, in some healthcare settings. Further, any healthcare strategy that distances patient testing from diagnostic laboratories reinforces the need for transport media.

Many users assume that commercial transport systems offer comparable performance characteristics, so cost alone may influence choice. However, a proposed NCCLS standard for transport media (M40) is likely to confirm significant variations in performance both between and different manufacturers’ products. Similarly, little attention has been given to the storage temperature for swabs after use; textbooks offer conflicting recommendations. Overgrowth and killing of NG in transport media by contaminating bacteria may be inhibited by refrigeration, but it is unclear whether refrigeration is detrimental to recovery of NG.
To address this we compared the survival of 30 distinguishable clinical strains of NG in charcoal transport swabs held at ambient temperature (AT: 20–22°C) and at 4°C. Swabs (Transwab: Medical Wire & Equipment Co) were inoculated with a suspension of NG in phosphate buffered saline (PBS). For each strain, four swabs were inoculated, to allow comparison of storage at AT or 4°C, for 24 or 48 hours. At times 24 hours and 48 hours, NG organisms were washed off the swabs by vortexing the tips in 1 ml PBS. Triplicate counts were performed on the 0 hour inocula and the washings on chocolate agar (Oxoid, Basingstoke, UK) using a spiral plater (Don Whitley, Shipley, UK). The median value for each triplicate was taken, and counts compared using the Wilcoxon rank sum test.

At 24 hours there was no significant difference between AT and 4°C counts, with median (interquartile range, IQR) recoverable log_{10}CFU of 4.57 (3.78–4.84) and 4.72 (4.32–4.87), respectively (fig 1). At 48 hours one strain held at AT was not recovered (see fig 1). At 48 hours, six strains held at AT and three at 4°C were not recovered; median counts (IQR) were 3.09 (1.3–3.55) and 3.855 (3.19–4.53) for AT and 4°C, respectively (p = 0.0004).

Sng et al in a semiquantitative study tested five strains in Amies medium at four temperatures (4, 18, 26, and 32°C) and found better survival at lower temperatures. Arbique et al studied six isolates and found refrigeration improved recovery, though optimum temperature varied with system. Perry et al using 11 isolates considered that 4°C prolonged survival. Studies using laboratory control strains of NG have usually shown better recovery at 4°C. It is impossible to reproduce in vitro the NG inoculum and other conditions in clinical swabs. To demonstrate a difference in survival at two temperatures we used a standardized inoculum. It is likely that not all the inoculum will be present in clinical samples. Nevertheless, our results add to a growing body of evidence that, compared to AT, refrigeration does not compromise the recovery of NG. Storage at 4°C offers potential benefits of reducing overgrowth and elimination of NG by contaminating normal flora.

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Sex Transm Infect 2005 81: 92-93
doi: 10.1136/sti.2004.009241

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