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 fourth (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 non-medical providers; the remaining three by medical providers. Respondents paid for circumcision: parents, peers, women, and circumcisers assumed various roles in its adoption. Respondents' circumcisers included medical 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 penises 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.

**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 “supot” 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)

**Acknowledgements**

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**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 ocugonital 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 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 they had not travelled outside Germany during the past year.

In all cases genital *C trachomatis* infection was diagnosed by DNA amplification in lesional 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...
for 3 weeks, while patient 1 received doxycycline for 1 week only.

The underlying *C. trachomatis* serovars were identified by sequence analysis of ompA derived DNA fragments amplified using primers MF21 and MB22 as described by Dean et al.1 In all cases the sequences obtained had highest homology to *C. trachomatis* serovar L2 but were not identical. While the sequence from patient 1 was shown to be 100% identical to the L2 isolate 434/Bo1 434/Bo1 from north India and the sequence from patient 1 was 100% identical to the L2 isolate 434/Bu1 434/Bu1 from Rotterdam,13 there is yet no identical sequence from patients in Germany; meyer@labor-arndt-partner.de

In conclusion, infections with *C. trachomatis* serovar L may be more frequent than expected. The frequency of serovar L2 was identified in all patients.

In conclusion, infections with *C. trachomatis* serovar L may be more frequent than expected. The frequency of serovar L2 was identified in all patients.

Figure 1  DNA sequence alignment of MOMP-PCR fragments. Nucleotide numbers are according to *C. trachomatis* serovar L2. Figure 1 demonstrates the sequence homology of the three different strains, as indicated by the shading of the sequence alignments. The nucleotides are numbered from the start of the sequence. The shading indicates how well the sequences are aligned. The sequences from patients 1 and 1007 are identified as 100% identical (96.9%, 1006). The sequence from patient 1 was shown to be 92.5% identical to the L2 isolate 434/Bo1 434/Bo1 from north India and the sequence from patient 1 was 100% identical to the L2 isolate 434/Bu1 434/Bu1 from Rotterdam,13 there is yet no identical sequence from patients in Germany; meyer@labor-arndt-partner.de

### 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 (&lt;100/μl)*</td>
<td>62 (7–152)</td>
<td>36 (7–111)</td>
<td>0.029</td>
</tr>
<tr>
<td>Pericardial effusion*</td>
<td>1.2%</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, antituberculosis treatment; PCP, *Pneumocystis jiroveci* pneumonia.

*Data are presented as median (interquartile range); p values determined by Mann-Whitney U test.

1Data are presented as mean (SD); p value determined by independent t test.

2Data are expressed as proportion; p values determined by χ² test.
and a national referral centre, this is expected. None the less, it may be possible that some OIs remained undiagnosed and indirectly influenced 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, C4+ 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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References

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 between both manufacturers' products. Similarly, little attention has been given to the storage temperature for swabs after use; textbooks offer conflicting recommendations. Over-growth and killing of NG in 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 at 4°C, for 24 or 48 hours. At 24 hours and 48 hours, NG organisms were released from the potential 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, UK) for the 0 hour inoculum 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, with median (interquartile range, IQR) recoverable log$_{10}$cfu of 4.57 (3.78–4.84) and 4.72 (3.19–4.53) for AT and 4°C, 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 ($p = 0.004$).

Sng et al in a semiquantitative study tested five strains in Amies medium at four temperatures (4, 18, 26, and 32 °C) and found five strains in Amies medium at four temperatures (4, 18, 26, and 32 °C) and found. Perry et al 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, 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 24 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 ($p = 0.004$).

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 optimal 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 higher than that likely to 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 the additional benefit of reducing overgrowth and elimination of NG by contaminating normal flora.

**Table 1** Chlamydia prevalence by age in men attending GUM clinic and undergoing community based testing

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Postal testing</th>
<th>GUM 2002</th>
<th>GUM 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15</td>
<td>6.7% (1/15)</td>
<td>16.7% (1/6)</td>
<td>0.0% (0/7)</td>
</tr>
<tr>
<td>15–19</td>
<td>13.7% (57/416)</td>
<td>14.2% (50/351)</td>
<td>19.4% (74/382)</td>
</tr>
<tr>
<td>20–24</td>
<td>12.6% (42/334)</td>
<td>17.4% (208/1194)</td>
<td>16.7% (217/1299)</td>
</tr>
<tr>
<td>25–29</td>
<td>12.0% (14/117)</td>
<td>13.0% (128/981)</td>
<td>11.3% (108/953)</td>
</tr>
<tr>
<td>&gt;29</td>
<td>1.4% (1/70)</td>
<td>6.7% (116/1728)</td>
<td>6.3% (101/1598)</td>
</tr>
<tr>
<td>Total</td>
<td>12.0% (115/952)</td>
<td>11.8% (504/4258)</td>
<td>11.8% (500/4239)</td>
</tr>
</tbody>
</table>

**Chlamydia in heterosexual men: could peak prevalence be in teenagers?**

The CMO’s expert advisory group on *Chlamydia trachomatis* and the Health Protection Agency (HPA) both state that rates of chlamydial infection are highest among 16–19 year old females and 20–24 year old males. Staff based in the genitourinary medicine (GUM) department in Edinburgh have set up a number of community based initiatives, including a postal testing service, to improve access to chlamydia diagnosis for young people aged less than 25.

Many of these initiatives have been targeted specifically at young men, with testing having been made available in a variety of novel settings such as young people aged less than 25 years attending GUM clinics. There is a trend towards younger transmission.

Although we only report on 2 years’ data, it will be essential to monitor ensuing trends by concentrating efforts to include teenage men in chlamydia testing programmes.

**References**

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S T Sadiq should be the last author for both letters.
Refrigeration does not compromise recovery of Neisseria gonorrhoeae from charcoal transport swabs

J J Wade and M A Graver

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