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 today. Circumcision was performed predominantly by non-medical providers; the remaining three by medical providers. Respondents paid for their circumcision in cash (51.8%) or in kind (6.1%); more than a third (36%) said that they used the services at no cost but by courtesy of the community and extension workers. The majority of respondents (51.7%) were circumcised between ages 10 and 14. Others had the same experience before age 10 or between 15 and 18 (5.3%).

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>75</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>14</td>
<td>12.3</td>
</tr>
<tr>
<td>7. To court a girl, have a girlfriend and get married</td>
<td>12</td>
<td>10.5</td>
</tr>
<tr>
<td>8. Women like to have sexual intercourse with a man whose penis is circumcised</td>
<td>2</td>
<td>1.8</td>
</tr>
</tbody>
</table>

*Multiple response (n = 114)
for 3 weeks, while patient 1 received doxycycline for 1 week only.

The underlying Chlamydia 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/Bu707,766 the sequences from patients 2 and 3 were only 99.8% (WH) and 99.5% (LL), respectively.

In conclusion, infections with C trachomatis serovar L may be more frequent than previously assumed, as indicated by the serovar L may be more frequent than in Rotterdam.2 Although anonymous sexual contacts in Germany were reported, there is yet no evidence of infection among homosexual men in Rotterdam2 with C trachomatis serovar L2. 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 toxoplamosis (n = 5), cytomegalovirus retinitis (n = 3), visceral leishmaniasis (n = 2), and progressive multifocal leucoencephalopathy (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 an 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...
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.

The recent proposals/debate addressing the Department of Medicine, All India Institute of Medical Sciences, New Delhi, India potentially fatal OIs were not diagnosed where it was found that a large number of OIs remained undiagnosed and expected. None the less, it may be possible and a national referral centre, this is expected to manage 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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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. Chlamydial screening will require extensive and expensive resources to provide 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 of service. 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 therefore 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.

(8) The provisions of service should be based primarily on clinical needs, with a clearer understanding of the difference between screening and testing. The task of providing screening (for example, for chlamydia) in primary care (leading to the cascade of recall of positive cases, the treatment of patients’ conditions, and the referral for contact tracing) should be implemented fully in primary care, before any other directives.

(9) Primary care units, providing full testing for STIs, should follow the same clinical governance and quality assurance standards expected and provided in GUM clinics. The issues of access, confidentiality, free prescriptions, and reporting conditions (coding: KC60) have not been addressed yet in primary care settings.

I propose the following alternative models of service.

(1) “Three tiered” GUM services are provided within 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 GUM services (for example, HIV, sexual dysfunction, genital dermatosis, forensic genitourinary medicine). It will be provided by specialised medical staff, assisted by specialised nurses, where junior grades attend for training.

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

(3) The provision 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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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 commercial media must be the choice. However, a proposed NCCLS standard for transport media (M40) is likely to confirm significant variations in performance between both generic and manufacturer’s 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 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 recovered 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 (3.19–4.53) for AT and 4°C, respectively (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 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 standard inoculum high enough to show that 4°C is 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.

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<table>
<thead>
<tr>
<th>Table 1</th>
<th>Chlamydia prevalence by age in men attending GUM clinic and undergoing community based testing</th>
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</thead>
<tbody>
<tr>
<td>Age groups</td>
<td>Postal testing</td>
</tr>
<tr>
<td>&lt;15</td>
<td>6.7% (1/15)</td>
</tr>
<tr>
<td>15–19</td>
<td>13.7% (57/416)</td>
</tr>
<tr>
<td>20–24</td>
<td>12.6% (42/334)</td>
</tr>
<tr>
<td>25–29</td>
<td>12.0% (14/117)</td>
</tr>
<tr>
<td>&gt;29</td>
<td>1.4% (1/70)</td>
</tr>
<tr>
<td>Total</td>
<td>12.0% (115/952)</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’s sexual health and drop-in clinics, further education (FE) colleges, community pharmacies, sports centres, and a high street shop selling CDs. The works forms part of a demonstration project called Healthy Respect that is funded by the Scottish Executive with the aim of helping people in Lothian to develop a positive attitude to their own sexuality and that of others. The long term goal of the project is to reduce teenage pregnancies and sexually transmitted infections.

Between February 2002 and December 2003, as part of the Healthy Respect project, we carried out 4838 chlamydia tests including 2321 from postal testing kits. The overall prevalence of chlamydial infection was 9.5% (10.4% in men, 9.0% in women). Somewhat to our surprise, the 15–19 year old age group showed peak prevalence in men as well as in women.

We compared this with the prevalence by age in men attending Edinburgh GUM (see table 1), anticipating this would be highest in the 20–24 year old age group. Although this was the case for 2002, in 2003 the peak prevalence was in 15–19 year olds, with the proportion of all positive tests in men as a result of the under 20s increasing significantly from 10.1% (51/504) in 2002 to 14.8% (74/503) in 2003 (χ² 5.05; p = 0.025).

There is no doubt that in men, the age group 20–24 accounts for the highest number of cases diagnosed, but our data raise the possibility that either there has been under-diagnosis of cases in younger men or that there is a trend towards younger transmission. Although we only report on 2 years’ data, it will be essential to monitor emerging trends by concentrating efforts to include teenage men in chlamydia testing programmes.

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