ISSN 2073-9990 East Cent. Afr. J. surg

Foreskins: Leave Them Alone

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Reproduced from Tropical Doctor 2014; Vol 44(1) 19–20

"You have not cut off enough"– after that remark from an uncle in my outpatient clinic in Malawi 30 years ago, I decided 'no more ritual circumcisions. How much was 'enough'?

Continuing with only clinically indicated circumcisions, I occasionally used the foreskin as a flap to cover degloved digits (anchoring the hand to the thigh with sutures and strapping it for a few days) and also as a free skin graft and in hypospadias repair. The foreskin was used most dramatically in scrotal elephantiasis. Here the mass is lifted by assistants and a tourniquet is wound several times around its base. This mass, often several kilos in weight, is removed (usually falling on the floor!). After haemostasis, the tourniquet is released and the testes pushed under the groin skin. The penis, which for years has been hidden in a tunnel, is revealed at last. The attached and usually thin foreskin is pushed back over the penis. This will only partially cover it, so flaps from the abdomen or groin are needed.

When, 20 years ago, it was suggested that circumcision might protect against infection with HIV, I was amused–the highest HIV prevalence in Malawi is in districts where there are the largest number of tribal circumcisions. Removal of the Langerhans receptor cells and keratinization of the glans was the rationale.

A mischievous verse composed itself: In a dish a little foreskin cried: ***'Look at the state I'm in. Labelled a receptor and not a protector. That was my sin. So I was cut off and flung in this bin'.***

When three circumcision test trials in Uganda, Kenya and South Africa were published, there were doubts over their validity–sexual behaviour, tribal genetic factors, and the artificial clinical situation could not be controlled. It was astonishing in 2007 when the World Health Organization (WHO) stated circumcision was an important strategy in the prevention of HIV infection in men and then recommended that condoms should be also be worn. This, at least, would also protect females. Why recommend the expense and trauma of this operation? What does '60% less risk of HIV-infection' mean to an individual? Would this be used to obtain misinformed consent? Are circumcision clients first tested for HIV? Increased risky behaviour by newly circumcised men is likely.

However, the major concern came later when African health ministers and donor funds took up the message. Too many ideas promoted by the rich to benefit the poor lack understanding of the local situation. Foreign funding would take staff away from a fragile, struggling health service to attend seminars. Some were minimally successful but came at a huge expense. Many times I travelled to district hospitals for a surgical visit, only to find that the staff had gone to workshops on, for example, breast-feeding, stigma, play in childhood or gender. Per diems greatly exceeded their normal salary. I was glad for the staff, sad for the patients left unattended in overcrowded wards and angry that the sponsors could get away with it. A few posters could give their simple messages.

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Most of the basic surgery in Malawi is done not by doctors but by paramedic clinical officers in difficult situations. This is similar to that seen in other poor countries. Sutures, dressings, scalpels, etc. are often out of stock. There is a large unmet need for surgery. Perhaps six circumcisions, using various methods and devices, could be done in the time taken for one necessary hernia repair. It has been suggested that 15–50 circumcisions might prevent one HIV-infection per year (fantasy figures vary). Would we now see scarce operating time, skilled personnel, equipment and drugs set aside for the circumcision lists? How many elective operations would be cancelled and how many lifesaving ones delayed for this futile procedure? Do 'they' realize what they might set in motion?

Thanks to donor support, antiretroviral (ARV) drugs management has been a qualified success but access to regular drugs is often difficult. A number of treated and improved patients have a detectable viral load (perhaps 9%). Unlike most diseases, HIV when treated may continue its spread. In Africa, 57% of AIDS victims are female. The place of surgery in AIDS is surely bilateral tubal ligation and termination of a pregnancy in order to preserve the health of the mother.

There is a good reason for circumcision—phimosis—but there are none for horrible female genital mutilation. Many theories have suggested reasons for the ancient origin of ritual circumcision – social cohesion, increased fertility, and the numbers in a tribal group in a competitive world. The threats that face us today—famine, pollution, viral plagues and conflicts—are largely due to overpopulation. It is true that medicine and surgery increase our numbers but we cannot bear too much reality and those are big matters.

However in the little matter of foreskins over the millennia we have cut off more than enough. Let's stop.

Acknowledgement

The Editor wishes to thank the Editor of the Tropical Doctor and Dr. Michael King for allowing the ECAJS to reproduce this article.

Comments from the readers about this topic are welcome.