

Traditional circumcision – the unkindest cut of all

'What kind of ritual is this that it now is killing our children?'
(mother of a male Xhosa initiate)¹

To the Editor: Twenty years ago two Eastern Cape urological surgeons documented their experience with treating initiates of *umkhwetha*, the ancient custom of ritual circumcision practised by the amaXhosa people of southern Africa. Crowley and Kesner followed up 45 consecutive patients and documented a mortality rate of 9%.² Recent press reports from the Eastern Cape claim an annual death rate of more than 70 per year.³ The death toll for the 2010 winter initiation period stood at 40 at the time of writing.⁴ These statistics not only point to the fact that little has changed, but suggest that the situation may in fact be deteriorating.

While the deaths write headlines, the misery goes much further; 150 youths are said to be attending hospitals in Eastern Cape for 'botched circumcisions',⁴ with results ranging from wound infections to gangrene to total penile loss. Twenty-two young men are reported to have suffered 'penile amputations'.⁴

Much academic socio-medical research has been done to understand and explain the complex circumstances leading to these deaths and mutilations.^{1,5} In addition to this important research, countless programmes have attempted to sanitise the practice. Yet if progress is counted in lives, the efforts appear to have been wasted.

Kepe has eloquently mapped the terrain of the current crisis into two distinct components.⁵ Firstly a 'public health nightmare' exists, created by the morbidity and mortality caused by ritual circumcision among the amaXhosa. Secondly, there is mounting tension between traditional leaders and government. Traditional leaders cite interference and violation of cultural rights, while the government has instituted prevention programmes and in 2001 promulgated the Circumcision Act in the Eastern Cape.

Dan Ncayiyana, editor of the *SAMJ*, has campaigned for changes to circumcision practice. He has labelled the circumcision schools as 'deadly' and their claims of offering a genuine rite of passage as fake.⁶ He sees solutions in certified training of traditional surgeons, a registry of accredited schools, and regular inspection of the schools.

Considering what little progress the many initiatives by government and health care providers have made, is it not time to recognise that the root of the problem lies with traditional leaders? Until government finds the courage to prosecute in court traditional leaders in whose name the circumcision schools are run, no progress can be achieved in the fight against this preventable loss of life.

John Lazarus

Division of Urology
Groote Schuur Hospital and
University of Cape Town
j.lazarus@uct.ac.za

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Clinical haematology training in South Africa

To the Editor: I read Dr Mlombe's letter on clinical haematology training in South Africa in the June *SAMJ*¹ with interest. Patients with haematological disorders must be treated with a seamless connection between the laboratory and the clinic. The FCPATH (SA) (Haem) (Fellowship of the Colleges of Pathologists of South Africa in Haematology) final exam also includes clinical cases.²

I was the secretary of the South African Society for Haematology (SASH) at the time of the inception of the subspecialty of clinical haematology in 1997,³ and would like to sketch the background. Before that time haematologists could either train as haematological pathologists, or as paediatricians or physicians. In the latter two specialties there were no formal qualifications in haematology. During the early 1990s eminent South African haematologists tried to unify the profession of haematology, so that haematologists would be equally comfortable in the laboratory and at the bedside, as recommended by the International Society of Haematology.^{4,5} A similar model is followed in the UK, where haematologists first complete an MRCP (Membership of the Royal College of Physicians), followed by the FRCPATH (Fellowship of the Royal College of Pathologists in Haematology) by examination, before being eligible for registration as a specialist. The training is regulated by the Joint Royal Colleges of Physicians' Training Board (JRCPTB).⁶

However, in the mid-1990s the then Interim National Medical and Dental Council supported the idea of subspecialties rather than creating new specialties. Thus the subspecialty of clinical haematology came into being, which allows haematological pathologists to gain clinical training, and physicians and paediatricians to gain laboratory training. This is similar to training in the subspecialty of infectious diseases, where there is cross-training in microbiology laboratory and clinical medicine.⁷ This does not affect the significance of dedicated pathologists. Specialists from various backgrounds train in the subspecialties of intensive care and gastro-enterology.

As mentioned in the letter, clinical haematology is regarded purely as a subspecialty of internal medicine in many parts of the world. The curriculum does not involve significant laboratory training, and this model works well in many countries. In my opinion, however, clinical haematologists must be trained in both laboratory and clinical medicine, which equips clinical haematologists trained in South Africa to be the best professionals to manage haematological conditions. The subspecialty is growing. It is fortuitous that 2010 is the centenary of the publication of the seminal Flexner Report,⁸ which emphasises the importance of basic medical science in medical education.

M J Coetzee

Department of Haematology and Cell Biology
University of the Free State
Bloemfontein
coetzeejmj@ufs.ac.za

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Vuvuzelas: *Ex Africa semper aliquid novis* – again?

To the Editor: The vuvuzela, or *lepatu* (Tswana), or 'stadium horn', has recently become an object of intense interest because of its prominence during the FIFA World Cup in South Africa. Its history has been well documented.¹ We all now know what a vuvuzela is. Its monotonous sound, if produced simultaneously by, say, 40 000 soccer enthusiasts, can fill an entire stadium for hours on end, to the intense irritation of players, coaches, non-participating spectators, TV audiences, and many more (for miles around the stadium).

The impact of the vuvuzela on the human ear has recently been studied, and the recreational risk that vuvuzelas pose to spectators in a stadium is significant.² It may also disseminate droplet-spread infections and be used as a weapon by soccer hooligans; among other things, it has been described as 'an instrument from hell!'

Despite these negatives, Mr Sepp Blatter felt that 'We should not try to Europeanize an African World Cup ... that is what African and South African football is all about – noise, excitement, dancing, shouting and enjoyment.'¹ Therefore, as a voice of moderation in favour of the accursed instrument, FIFA permitted the vuvuzela to be used in the 2010 WC stadia. And the 2010 FIFA WC went off well. A minimum of crime was reported, and no significant soccer hooliganism. There was even a respectful hush before each national anthem. South Africa scored very high points in the international media for the way in which the WC was presented.

I am of the considered opinion that the vuvuzela must have played a role in pacifying the crowds – possibly by keeping its users occupied. It kept their hands, mouths, lungs and minds busy while at the same time producing noise. There was apparent competition between users to see who could make the most noise. People of all ages, sexes and colours blew the vuvuzela. It even found its way into some royal circles. It must have had some energy-draining effect, energy that could otherwise have swelled into soccer hooliganism or even crime. It seemed to have some binding effect on fans from various countries. If indeed some potentially 'bad' energy, however little, was dissipated in this way, and if indeed it possibly had some unifying, positive, syncretic effect between peoples of different ethnic groups and nationalities, then I would be quite happy to continue living with the vuvuzela, even if it means some degree of hearing loss and living with some noise pollution. After all, Africa is a loud, bright, noisy and sometimes infernal continent.

In South Africa, we have just produced a new antiviral vaginal gel, which seems to be effective; we have produced yet another golf

champion; and we have put the vuvuzela in the limelight. Possibly the vuvuzela is not all bad news. As the old Romans said: *Ex Africa semper aliquid novis*. (There is always something new out of Africa.)

J du T Zaaïjman

Middelburg, Eastern Cape
zaaij@adsactive.com

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CRP and toxic granulation

To the Editor: I read the article on CRP and toxic granulation with great interest.¹ The authors concluded: 'The proposed system can be applied to patients with inflammatory or infectious conditions, where grading of toxic granulation of neutrophils can possibly be used as a surrogate marker to assess infection or inflammation and their response to treatment.'¹ I agree that the new system can be useful in clinical practice. However, there are some points of concern. Firstly, the assessment of toxic granulation must be based on experienced clinical microscopy;² this might not be available in rural hospitals. Secondly, there are many confounding factors that can affect the CRP level, and this aspect was not totally controlled in the article.³

Viroj Wiwanitkit

Wiwanitkit House
Bangkok
Thailand 10160
wviroj@yahoo.com

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Dr Van de Vyver replies: Laboratory confirmation of the presence of inflammation can be problematic in certain settings. This is a particular issue in settings where anti-inflammatory drugs – especially corticosteroids – are administered. In this setting, a combination of assays is usually employed to provide a cumulative impression of the presence or absence of infection or inflammation. C-reactive protein (CRP) is a widely utilised assay in the evaluation of inflammation. As with most immune assays, various factors can theoretically interfere with the final value reported. However, this seems to be a significant problem with highly sensitive assays (measuring levels below 10 mg/l)¹ as opposed to assays measuring levels in excess of 10 mg/l.²

We agree that assessment of toxic granulated neutrophils requires an experienced technologist, unfortunately not generally available in rural areas. The system is also potentially labour-intensive, with reproducibility highly dependent on the training of the examiners.

Toxic granulation can only serve as an additional tool to assess the presence of infection if there is diagnostic uncertainty. As a single parameter, it is of limited diagnostic value and can serve purely as a contribution to other infective markers.

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