Sexually Transmitted Diseases

Santa Cruz County

October 2011

Sexually transmitted diseases (STDs) are the most commonly reported of all communicable diseases in Santa Cruz County and comprised **more than 55%** of incidents of reported diseases among residents in 2010. Table 1 shows the numbers of selected STD cases reported in 2009 and 2010. There were over 100 more cases in 2010 compared to 2009. Also of concern is the striking increase in infectious syphilis cases thus far in 2011 (see page 2).

Table 1 – Reported STD Cases by Disease, Santa Cruz County Residents, 2009-2010.

Disease	2009 Cases	2010 Cases	Change
Syphilis (Infectious) [1]	10	13	▲
Gonorrhea	55	46	▼
Chlamydia	647	764	▲
Pelvic Inflammatory Disease [2]	20	37	▲
Total	**732**	**860**	▲

1: Infectious syphilis includes: primary, secondary and early latent cases.
2: Pelvic Inflammatory Disease includes cases from CT or GC as well as unknown etiologies.

In California, both healthcare providers and labs are required to report the following conditions to their local health department:

- Chlamydia (CT)
- Gonorrhea (GC)
- Syphilis
- Chancroid
- Lymphogranuloma venereum
- Pelvic Inflammatory Disease (PID)

If you diagnose an STD, please complete and fax an STD-specific Confidential Morbidity Report (CMR) to (831) 454-5049. The STD CMR is available at http://www.santacruzhealth.org/pdf/PH%20Reporting/09-STD_CMR.pdf. Please let your patient know that the Health Department may be contacting them (see page 4).

HIV/AIDS is also reportable, but through a different process, see http://www.santacruzhealth.org/pdf/PH%20Reporting/10-HIV_AIDS.pdf. For the most recent local HIV/AIDS summary, go to http://www.santacruzhealth.org/pdf/HIV-AIDS_quick%20sheet.pdf.

SCREENING

The State recently updated the California Sexually Transmitted Disease Screening Recommendations, 2010 http://www.cdph.ca.gov/programs/std/Documents/CA-STD-Screening-Recommendations-2010.pdf.

ROUTINE

It is recommended that women ages **25 and younger** be screened annually for GC and CT.

TARGETED

Among women **over age 25**, screening should be based on risk factors, such as:

- A new sex partner within the past 3 months
- More than one partner in the past 12 months
- A history of CT or GC in past 24 months
- Belief that a partner from the previous 12 months may have had other sex partners at the same time

EXPEDITED PARTNER THERAPY

Since 2007, California medical providers have been legally allowed to prescribe or dispense antibiotic therapy for the sex partners of patients infected with chlamydia or gonorrhea, even if they have not been able to perform an exam of the patient's partner (California Health & Safety Code §120582; more information at http://www.cdc.gov/std/ept/legal/california.htm). This is known as expedited partner therapy or EPT.

Timely and recommended antibiotic treatment needs to be provided to all partners who had sexual contact with the patient during the 60 days prior to diagnosis. If the patient's last sexual contact was over 60 days prior to diagnosis, the most recent sexual partner should be treated.

PATIENT INSTRUCTIONS

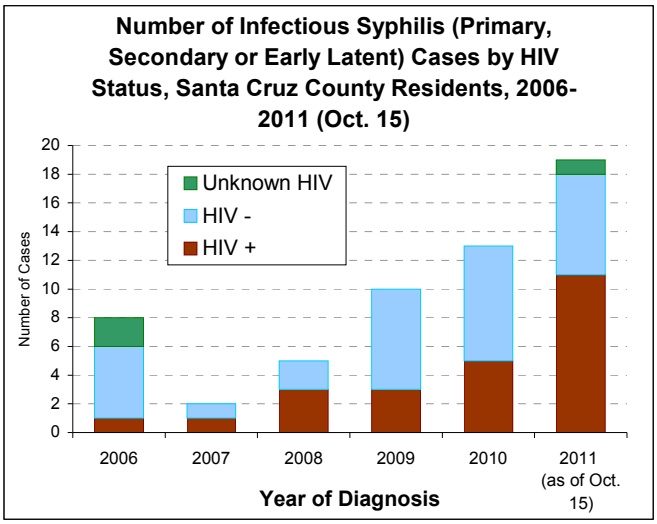
Patients should abstain from oral, anal and/or vaginal sex until they and their sex partners have completed treatment, i.e., 7 days in the case of a single-dose regimen or after the end of a 7-day therapy. Please do not advise condom use during this period as condoms have been known to break, and they are rarely used during oral sex.

SYPHILIS

In 2010, 12 (92%) of the cases of infectious syphilis (primary, secondary and early latent) in Santa Cruz County were **MSM** (Men who have Sex with Men) and nearly half (42%) were also **HIV+** MSM.

As of October 15th, there have already been **19** cases of infectious syphilis among residents of Santa Cruz County in 2011. The year is not yet over and yet the number is **nearly 2.5 times** the average annual case count in the past five years, which is less than 8 cases a year. Among the 2011 cases reported, 11 cases (58%) are also known to be HIV+ (see Figure 1). Santa Cruz County has too few cases for this increase to be statistically significant, but the data do mirror notable increases among San Francisco Bay Area counties.

Figure 1:



SCREENING MSM

The CDC has made the following STD screening recommendations for MSM to be done at least **annually**:

- HIV serology if HIV negative or not tested within the previous year
- RPR or VDRL syphilis serology
- Urine NAAT for chlamydia and gonorrhea
- Pharyngeal culture* for gonorrhea in men with oral-genital exposure
- Rectal gonorrhea and chlamydia culture* in men who have had receptive anal intercourse
- Hepatitis A and B immune status, if susceptible.

More frequent STD screening (i.e., at a **3-6 month** interval) is indicated for MSM who have multiple or anonymous partners or who have sex in conjunction with illicit drug use (particularly methamphetamine use) or whose partners participate in these activities.

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*Commercially available NAATS are not FDA cleared for these indications, but can be used by laboratories that have met all regulatory requirements for an off-label procedure.

SEROSORTING

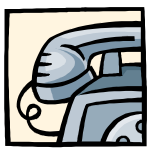
We have found through our syphilis case interviews that there has been an increase in the proportion of HIV+/MSM syphilis cases who report having unprotected anal sex with a partner of the same HIV status as themselves, also known as "serosorting." Serosorting by HIV status unfortunately does not decrease the risk of other STDs.

The Centers for Disease Control and Prevention recommend that persons who have been exposed to syphilis within the past 90 days should be treated with 2.4 million units of intramuscular benzanthine penicillin. Treatment should be provided regardless of the outcome of serology. This should include persons who report having only oral sex with a partner with syphilis.

Adopt a low threshold for testing and treating patients for syphilis. In particular providers should test all MSM with a new rash for syphilis.

SYPHILIS HISTORY SEARCH

If you have a patient with a history of syphilis but are unsure of past treatment or stage, please call Paula Haller, the Santa Cruz County STD Coordinator, at (831) 454-4114; she can search local and state registries for lab and treatment records.



GONORRHEA

Between 2008 and 2010, an average of **54** cases of gonorrhea were reported each year among Santa Cruz County residents. The majority of cases (60%) were male. However, among cases less than 20 years old, females had higher incidence rates compared to males (see Figure 2).

TREATMENT

In light of decreased *N. gonorrhoeae* susceptibility to third generation cephalosporins,[1] the latest California guidelines' recommendation includes dual antibiotic therapy, regardless of the chlamydia test result. **The recommended treatment for uncomplicated gonococcal infections of the cervix, urethra, rectum and pharynx is:**

New!

Ceftriaxone 250 mg. IM in a single dose

PLUS, either

Azithromycin 1 gm. po. in a single dose OR

Doxycycline 100 mg. po. bid x 7 days

[1] Centers for Disease Control and Prevention. Cephalosporin Susceptibility Among *Neisseria gonorrhoeae* Isolates — United States, 2000–2010. MMWR 2011;60:873-7.

Fluoroquinolones (e.g., ciprofloxacin, levofloxacin, ofloxacin) have not been recommended for gonorrhea treatment in California since 2002.

See the California STD Treatment Table for Adults and Adolescents, 2010 for alternative regimens, available at: http://cdph.ca.gov/pubsforms/Guidelines/Documents/CA-STD-Tx-Guidelines-BW.pdf [link repaired on 2-13-2012] **Cefixime is not recommended for pharyngeal infections.**

TEST OF CURE

Perform a test of cure (TOC) for the following:

- Pregnant women
- Pharyngeal GC infections not treated with ceftriaxone 250mg
- Any GC infections not treated with cephalosporins
- Suspected treatment failures

The ideal TOC method is a culture done approximately 1 week after treatment. If using a NAAT, wait at least 3 weeks to avoid a false-positive result.

TREATMENT FAILURES

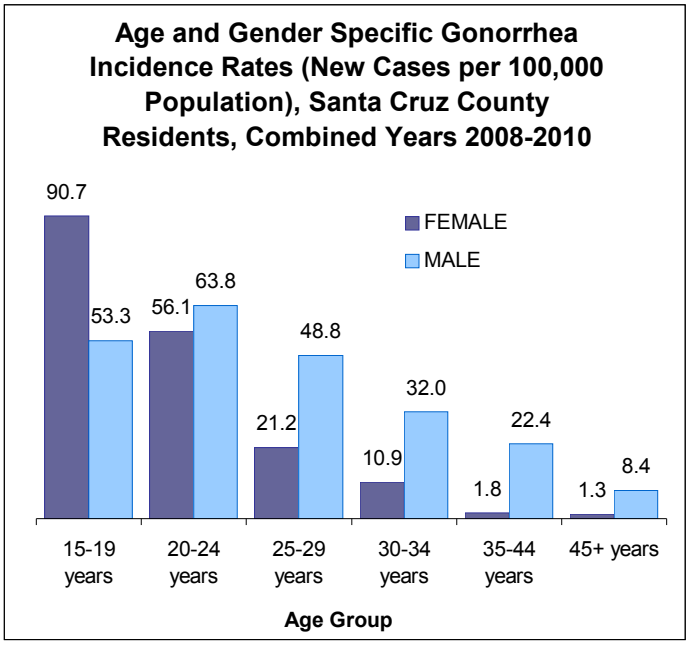
Symptoms of treatment failure vary greatly depending on the site of initial infection. Many pharyngeal, rectal, and cervical gonorrhea infections are asymptomatic. If symptoms are present 7 days following initial antibiotic treatment, then treatment failure should be suspected.

Patients who had sexual exposure to partners in the first 7 days after treatment are considered re-infected and not a treatment failure, and they should be retreated with one of the recommended antibiotic regimens.

For the most up-to-date protocols for suspected treatment failures, please consult http://cdph.ca.gov/pubsforms/Guidelines/Pages/CaGuidelinesGonorrheaTxFailure.aspx

If reinfection has been ruled out and treatment failure is still suspected, obtain a specimen for culture and sensitivity at the sites of sexual exposure. If a gonorrhea culture is not available from the lab serving your clinic site, contact the California STD Control Branch clinician warm line at (510) 620-3400, M-F 8am-5pm for assistance.

Figure 2:



CHLAMYDIA

Infection with *Chlamydia trachomatis* is the most commonly reported STD locally and nationally. In 2010, there were **764** cases among residents of Santa Cruz County, which is nearly 280 cases per 100,000 residents (see Figure 3). Females have higher incidence rates compared to males—especially under age 25, which is likely related to who gets tested (see Figure 4).

TEST OF CURE

A test of cure (TOC) at 3-4 weeks is only indicated in pregnant women. All patients diagnosed with Chlamydia should have repeat testing at 3 months to rule out re-infection. However, if compliance with treatment is in question or symptoms persist, a TOC may be warranted. **Retesting of chlamydia cases should not occur less than 3 weeks post treatment** due to the risk of false positive test results when using nucleic acid amplification tests (NAATs).

PID

The clinical diagnosis of acute PID (Pelvic Inflammatory Disease) is imprecise. Empiric treatment of PID should be initiated in sexually active women with pelvic or lower abdominal pain, if no cause of the illness other than PID can be identified and one or more of the following minimum criteria is present on pelvic examination:

- Cervical motion tenderness
- Uterine tenderness
- Adnexal tenderness

All women with suspected PID should be tested for chlamydia and gonorrhea and presumptively treated at the time of presentation. See the current State guidelines for treatment regimens. All women presumptively treated for PID should be reported to the health department regardless of causative pathogen. Partners of PID cases should be empirically treated for both chlamydia and gonorrhea.

HEALTH DEPARTMENT FOLLOW-UP

The Public Health Department routinely contacts all cases of syphilis, all cases of gonorrhea, and cases of chlamydia among persons age 20 and under. Chlamydia cases over age 20 who are pregnant if indicated on the CMR, first-time repeaters or cases with a request for follow-up are also contacted. However, as budgetary constraints increase, our ability to do comprehensive follow-up will likely decrease.

Figure 3:

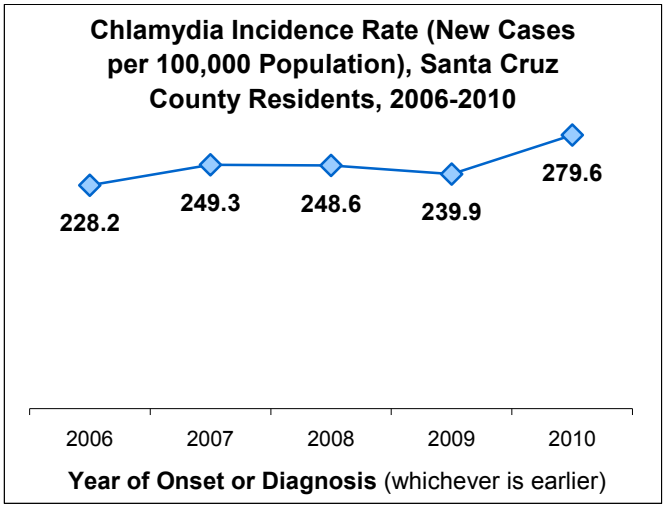
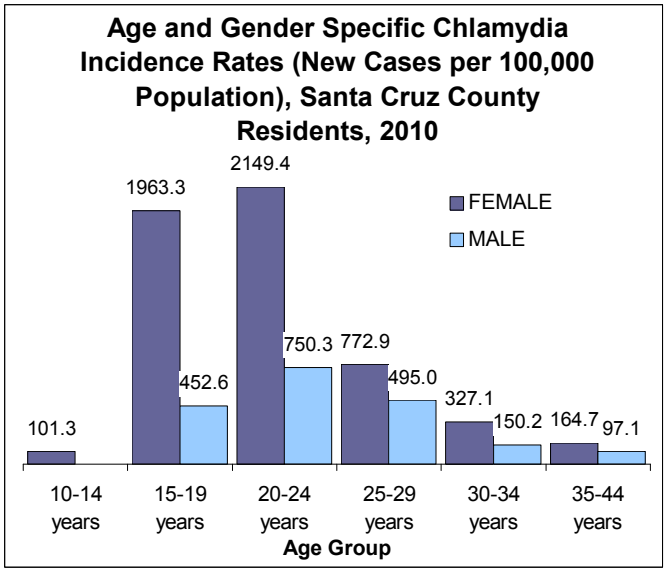


Figure 4:



*** NEWS *** On October 9, 2011, Governor Jerry Brown signed California Assembly Bill 499 which gives minors 12 and older the right to obtain **preventative treatment** for STDs without parental consent, including HPV (human papillomavirus) immunizations for cervical cancer.

For more information...

County of Santa Cruz
Dept. of Public Health, CD Unit
(831) 454 – 4114
http://www.santacruzhealth.org

Sources: Case Counts from County of Santa Cruz, Public Health Department, Communicable Disease Unit (Unpublished Data), as of October 15, 2011. Population Data from State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Presentation style adapted from Washington State Dept. of Health "STI Fast Facts: Washington State 2010"