



County of San Diego Monthly STD Report

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Table 1. STDs Reported Among County of San Diego Residents, by Month and Previous 12 Months Combined.

	2014 Previous 12- Month Period*	2015 Previous 12- Month Period*
	Dec	Dec
Chlamydia	1287	1512
Female age 18-25	508	594
Female age ≤ 17	64	70
Male rectal chlamydia	32	71
Gonorrhea	307	356
Female age 18-25	39	48
Female age ≤ 17	6	3
Male rectal gonorrhea	46	65
Early Syphilis (adult total)	69	73
Primary	11	16
Secondary	28	20
Early latent	30	37
Congenital syphilis	1	3
HIV Infection†		
HIV (not AIDS)	23	44
AIDS	19	13

* Cumulative case count of the previous 12 months.

† New infections are reported either as HIV, or if an individual was also diagnosed with AIDS within one month, as AIDS.

Table 2. Selected STD Cases and Annualized Rates per 100,000 Population for San Diego County by Age and Race/Ethnicity, Year to Date.

	All Races*		Asian/PI		Black		Hispanic		White	
	cases	rate	cases	rate	cases	rate	cases	rate	cases	rate
<i>All ages</i>										
Chlamydia	17416	560.7	117	31.4	382	276.4	941	87.2	927	61.1
Gonorrhea	3686	118.7	84	22.5	368	266.3	735	68.1	866	57.1
Early Syphilis	833	26.8	38	10.2	63	45.6	333	30.9	336	22.2
<i>Under 20 yrs</i>										
Chlamydia	2892	359.5	13	14.5	65	179.8	151	39.7	68	22.8
Gonorrhea	297	36.9	3	3.4	45	124.5	73	19.2	34	11.4
Early Syphilis	22	2.7	3	3.4	0	0.0	16	4.2	3	1.0

Note: Rates calculated using 2015 SANDAG population estimates.

* Includes cases designated as "other," "unknown," or missing race/ethnicity.

Figure 1. Chlamydia and Gonorrhea Reported Among County of San Diego Residents, by 3-Month Period.

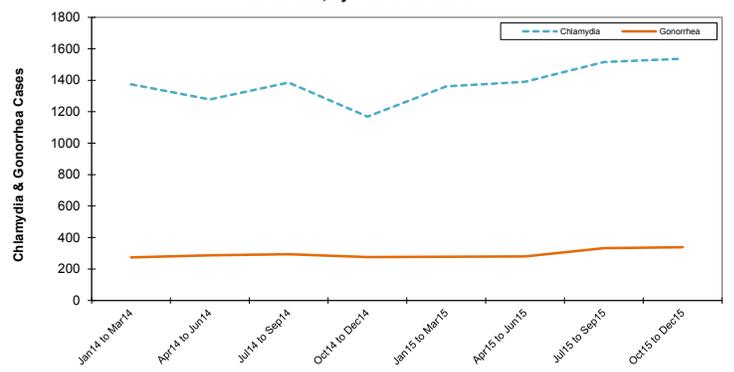
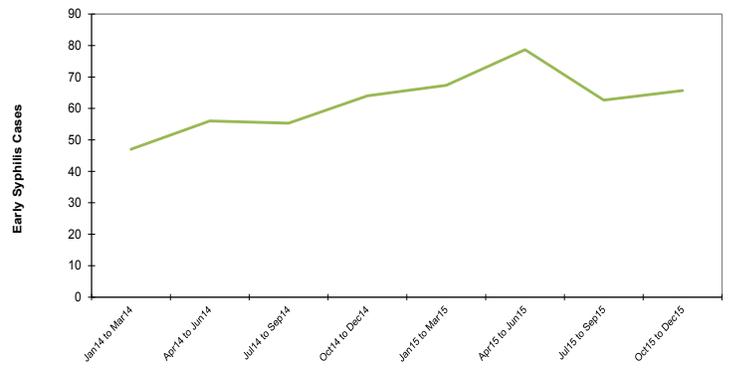


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Note: All data are provisional. Case counts are based on the earliest of date of diagnosis, date of specimen collection, and treatment date. Totals for past months might change because of delays in reporting from labs and providers.

Editorial Note: HIV Testing in Hospital Emergency Departments

More than 1.2 million people in the United States are living with HIV infection, and about one in eight (12.8%) are unaware that they are infected [1]. Since 2006, the Centers for Disease Control and Prevention (CDC) has recommended routine (i.e., non-risk-based) opt-out HIV testing in health-care settings, including primary care clinics and hospital emergency departments [2], and in 2013, the U.S. Preventive Services Task Force gave a Grade A recommendation for routine screening for HIV of adults and adolescents between 15 and 65 years of age [3].

These recommendations are based on the knowledge that earlier detection and treatment of HIV infection decreases progression to the acquired immune deficiency syndrome (AIDS), AIDS-related events, and death; mother-to-child transmission; and transmission to sexual and needle-sharing partners [3]. The availability of more advanced diagnostic tests, including fourth-generation screening assays that detect HIV-1 and HIV-2 antibodies and HIV p24 antigen, allows for more rapid detection of acute HIV infection, which usually presents with non-specific symptoms or none at all, and is the period during which patients are most infectious. It is estimated that around half of new HIV infections are transmitted by people who have recently been infected with HIV and are unaware of their status [4].

Emergency Departments (EDs) are key venues for detecting HIV infections, with 17% of adults accessing care only through the ED prior to the implementation of the Affordable Care Act (ACA) [5]. Further, symptoms such as fever, headache, generalized pain, and sore throat, which are frequently symptoms of acute retroviral syndrome, are common presenting complaints to the ED [6]. However, few EDs have implemented routine HIV testing, and approximately 0.3% of all ED visits nationally include HIV testing [7]. Commonly cited barriers include concerns regarding test processing time and its impact on patient length of stay, and test result follow-up and linkage to care [8]. Also, implementation of a public health initiative in acute care settings is controversial and is not popular among some ED physicians.

However, fourth-generation HIV screening tests have allowed for faster turnaround time of results (i.e., 60 minutes for negative results and 90 minutes for preliminary positive results). In places such as Maricopa County, Arizona [9] and Chicago, Illinois [8], feasibility of rapid testing with these assays has been demonstrated in ED-based HIV testing programs. Strategies contributing to the success of these programs included integration of HIV test ordering into established triage processes and shifting the responsibility of follow-up of test results and linkage to care from ED physicians to linkage to care specialists, social workers, and/or collaborating Infectious Disease specialists. Of new HIV diagnoses made through these programs, 20-23% were acute infections, highlighting the potential role of the ED in detecting those in the most infectious stage of HIV infection.

In conclusion, with the appropriate buy-in and infrastructure in place, HIV testing, with appropriate follow-up of results and linkage to care for those who test positive, can be implemented in acute care settings, such as EDs, without interfering with patient flow. Expansion of routine opt-out HIV testing to EDs may be particularly helpful in identifying individuals with recent HIV infection and reducing new infections.

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