County of San Diego Monthly STD Report

Volume 7, Issue 3: Data through March 2015; Report released July 8, 2015.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

	2014		2015	
	Mar	*Previous 12-Month Period**	*Mar*	*Previous 12-Month Period**
Chlamydia	1327	16119	1463	15689
Female age 18-25	528	6703	614	6388
Female age ≤ 17	62	804	62	666
Male rectal chlamydia	41	556	34	503
Gonorrhea	292	2994	266	3419
Female age 18-25	44	431	36	492
Female age ≤ 17	8	56	4	62
Male rectal gonorrhea	38	420	36	466
Early Syphilis (adult total)	59	550	57	683
Primary	10	109	15	125
Secondary	23	214	21	253
Early latent	26	227	21	305
Congenital syphilis	2	5	2	4
HIV Infection**				
HIV (not AIDS)	47	415	55	449
AIDS	20	259	35	254

* 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*
All ages										
Chlamydia	4190	524.7	29	31.6	74	215.1	164	61.4	142	37.9
Gonorrhea	849	106.3	13	14.2	87	252.9	168	62.9	173	46.2
Early syphilis	164	20.5	9	9.8	12	34.9	61	22.8	60	16.0
Under 20 yrs										
Chlamydia	757	357.6	1	4.6	16	178.0	35	36.6	12	16.5
Gonorrhea	65	30.7	1	4.6	11	122.4	16	16.7	7	9.6
Early syphilis	2	0.9	1	4.6	0	0.0	1	1.0	0	0.0

Note: Rates calculated using 2014 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.

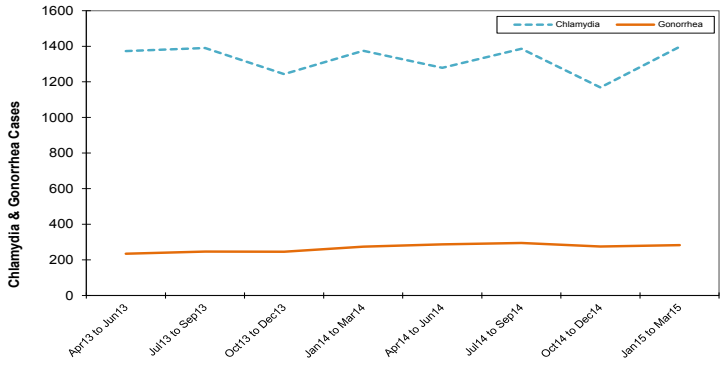
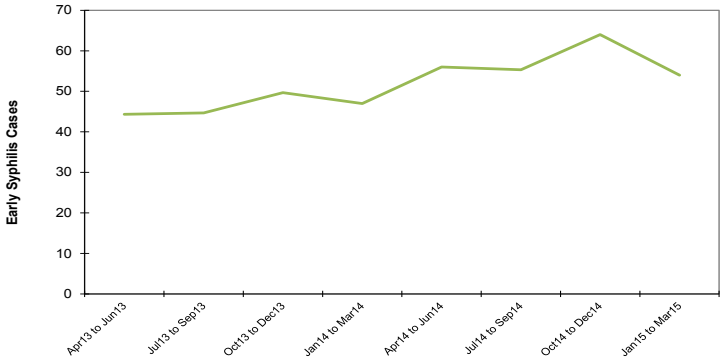


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



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.*

Updated CDC STD Treatment Guidelines

On June 4, 2015 the Centers for Disease Control and Prevention (CDC) released its 2015 Sexually Transmitted Diseases Guidelines. There were several changes in the treatment guidelines for *Neisseria gonorrhoeae* (GC) infections, which include the following highlights:

- For uncomplicated GC infections of the urethra, cervix, rectum and pharynx, the **only *recommended* treatment regimen** is **ceftriaxone 250 mg IM plus azithromycin 1 gram orally, both as single doses**.
- The combination of **ceftriaxone 250 mg IM plus doxycycline 100 mg orally twice daily for 7 days** has been changed from a *recommended* to an ***alternative* treatment regimen**, due to high rates of tetracycline resistance among GC isolates with decreased susceptibility to cephalosporins.
- **Monotherapy with azithromycin 2 grams orally as a single dose is no longer recommended as an *alternative* regimen for GC infections. Dual therapy should always be administered for GC infections on the same day and preferably under direct observation, regardless of the chlamydia test result.**
- Two **new *alternative* regimens** are now recommended for patients with a cephalosporin allergy. These include: **1) Gentamicin 240 mg IM plus azithromycin 2 grams orally, both as single doses** and **2) Gemifloxacin 320 mg orally plus azithromycin 2 grams orally, both as single doses**. Both of these regimens were highly efficacious for uncomplicated urogenital GC infections in a noncomparative randomized clinical trial, although nausea and vomiting were common[1].

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Updated CDC STD Treatment Guidelines (Continued)

- **Oral cefixime** should **not** be used to treat **pharyngeal** GC infections.

- A **test-of-cure (TOC)** is recommended **14 days after treatment** using either culture or nucleic acid amplification testing (NAAT) for any patient with **pharyngeal** GC infection who is treated with an ***alternative*** treatment regimen.

Other important changes/highlights include, but are not limited to, the following:

- **Amoxicillin** has been changed from a *recommended* to an ***alternative*** regimen for treatment of *Chlamydia trachomatis* in pregnant women due to concerns about chlamydia persistence following exposure to penicillin-class antibiotics. **Azithromycin 1 gram orally in a single dose is *recommended* for pregnant women with chlamydia**.

- The role of ***Mycoplasma genitalium*** is increasingly recognized as a significant **cause of non-gonococcal urethritis (NGU)**. Although NAAT testing for this organism is available in certain clinical and research settings, there is no FDA-cleared diagnostic test for *M. genitalium*. **Azithromycin 1 gram orally in a single dose** is more effective against *M. genitalium* than doxycycline 100 mg orally twice daily for 7 days, although susceptibility to azithromycin is declining. For patients with recurrent or persistent NGU that is not due to reinfection, azithromycin should be given if it was not part of the original treatment regimen. Men who have sex with women may also receive a recommended treatment regimen against *Trichomonas vaginalis*. NGU that persists or recurs despite treatment with azithromycin should be treated with **moxifloxacin 400 mg orally daily for 7 days**.

- **Imiquimod 3.75% cream** has been added to the list of recommended patient-applied treatment regimens for genital warts due to human papilloma virus (HPV). As with the 5% cream, it should be applied once **at bedtime** and washed with soap and water 6 to 10 hours after application and should be **given for up to 16 weeks**. However, unlike the 5% cream, it is applied **every night**.

- **Podophyllin resin** is now considered an ***alternative*** rather than a *recommended* treatment for external genital warts due to **reports of severe toxicity** and should be given only if strict adherence to the recommendations for application will be followed.

- Due to accumulating evidence of **acute Hepatitis C Virus (HCV) infection in persons with HIV infection**, particularly men who have sex with men (MSM), **HCV antibody screening** should be performed at initial evaluation and considered **at least yearly thereafter in those at high risk of infection**. More frequent screening should be performed in **areas with high HCV prevalence, in patients who engage in high-risk and traumatic sexual behavior and in patients with concomitant ulcerative STDs and proctitis due to STDs**.

- The **use of highly sensitive and specific tests** is recommended for detecting ***T. vaginalis***. **NAAT** is highly sensitive in women and is recommended over wet-mount microsopy, which has poor sensitivity (51-65%). Two rapid tests are FDA-approved for detection of *T. vaginalis* in vaginal secretions, with intermediate sensitivity compared to wet-mount microscopy and NAAT.

- Due to high rates of reinfection among women treated for trichomoniasis, retesting for ***T. vaginalis*** is recommended within 3 months following initial treatment, regardless of whether or not sexual partners are thought to have been treated.

- **Treatment is recommended for all symptomatic pregnant women with bacterial vaginosis**. This recommendation is based on studies that have demonstrated the efficacy of BV treatment in this population and the failure of multiple studies and meta-analyses to demonstrate an association between metronidazole use during pregnancy and adverse effects on newborns.

- Other resources, such as wall charts and pocket guidelines, are available through the CDC at http://www.cdc.gov/std/tg2015/default.htm.