County of San Diego Monthly STD Report

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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.

	2017		2018	
	Dec	*Previous 12-Month Period**	*Dec*	*Previous 12-Month Period**
Chlamydia	1611	20819	1666	21972
Female age 18-25	616	7872	619	8233
Female age ≤ 17	56	887	58	965
Male rectal chlamydia	37	505	76	1055
Gonorrhea	522	5966	461	6200
Female age 18-25	80	723	73	969
Female age ≤ 17	6	102	9	106
Male rectal gonorrhea	48	862	56	762
Early Syphilis (adult total)	93	1123	90	1075
Primary	15	184	14	168
Secondary	30	390	26	374
Early latent	48	549	50	534
Congenital syphilis	1	11	4	17

* Cumulative case count of the previous 12 months.

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	21972	663.9	430	109.3	1015	642.7	1965	177.7	2576	168.2
Gonorrhea	6200	187.3	143	36.3	634	401.5	1327	120.0	1267	82.7
Early Syphilis	1080	32.6	69	17.5	100	63.3	424	38.4	405	26.4
Under 20 yrs										
Chlamydia	3807	463.3	43	52.0	185	484.2	343	92.0	360	130.1
Gonorrhea	532	64.7	7	8.5	68	178.0	146	39.1	79	28.5
Early Syphilis	24	2.9	3	3.6	1	2.6	13	3.5	7	2.5

Note: Rates calculated using 2017 Preliminary Population Estimates; County of San Diego, Health and Human Services Agency, Public Health Services Division, Community Health Statistics Unit. 7/2018.

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

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.*

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

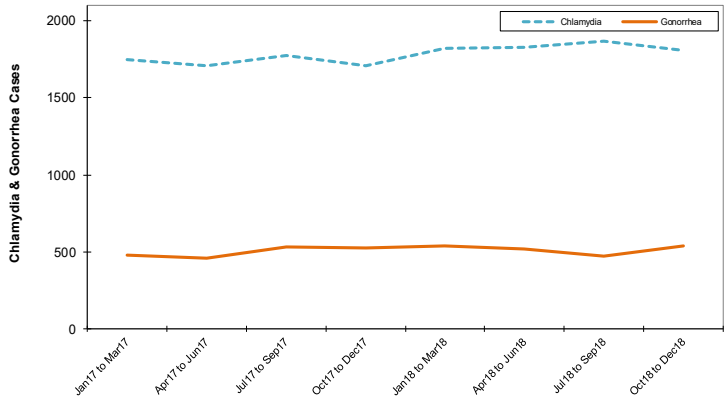
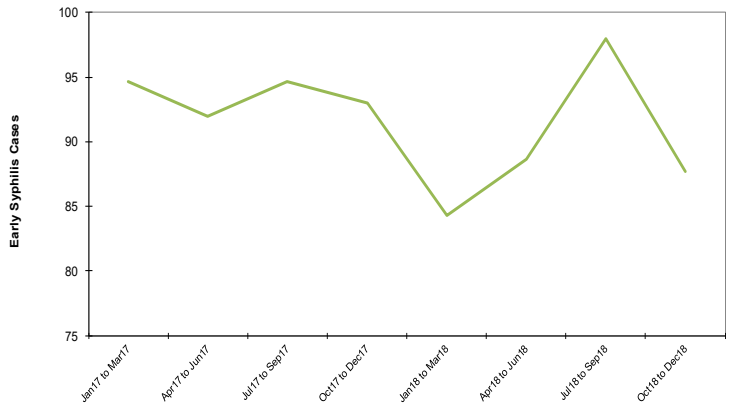


Figure 2. Early Syphilis Reported Among County of San Diego Residents, by 3-Month Period.



Editorial Note: Recent Updates in Gonorrhea Diagnostic Testing and Treatment

On May 23, 2019, the United States Food and Drug Administration (FDA) approved two nucleic acid amplification tests (NAATs) for the detection of *Neisseria gonorrhoeae* (GC) and *Chlamydia trachomatis* (CT) on extragenital (i.e., throat and rectal) specimens. The FDA granted clearance of the APTIMA Combo 2 Assay and the Xpert® CT/NG to Hologic, Inc. and Cepheid respectively[1]. For men who have sex with men (MSM), the Centers for Disease Control and Prevention (CDC) recommends screening for urethral/urinary and rectal GC and CT, as well as pharyngeal GC, as indicated by exposure[2]. The California Department of Public Health (CDPH) recommends at least annual GC/CT screening at all exposed sites for sexually active people living with HIV, regardless of gender, and HIV-negative MSM who are not using HIV pre-exposure prophylaxis (PrEP). CDPH recommends quarterly GC/CT screening at all exposed sites for HIV-negative MSM using HIV PrEP [3]. These recommendations are based on the high proportion of MSM with extragenital GC and CT who do not have concurrent urethral infection (i.e., the GC or CT infection would be missed if only urine/urethral screening was performed)[4].

Regarding gonorrhea treatment, a randomized controlled trial comparing gentamicin 240 mg intramuscularly (IM) with ceftriaxone 500 mg IM, both given in combination with one gram of oral azithromycin as single doses, failed to demonstrate noninferiority of gentamicin for treatment of uncomplicated gonorrhea. While both gentamicin and ceftriaxone were effective in clearing genital infection (151 of 154 (98%) in the ceftriaxone group compared with 163 (94%) of 174 in the gentamicin group, adjusted risk difference -4.4%, -8.7 to 0), gentamicin was inferior to ceftriaxone in clearing pharyngeal (108 (96%) in ceftriaxone group compared to 82 (80%)

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Editorial Note: (Continued)

in the gentamicin group, adjusted risk difference -15.3%, -24.0 to -6.5) and rectal infections (134 (98%) in the ceftriaxone group compared with 107 (90%) in the gentamicin group, adjusted risk difference -7.8%, -13.6 to -2.0). Therefore, gentamicin does not appear to be appropriate as first-line therapy for gonorrhea but is potentially useful for patients with isolated genital infection or for patients for whom ceftriaxone is contraindicated[5].

The CDC currently recommends gentamicin 240 mg IM, in combination with azithromycin 2 grams orally, both as single doses, only for *alternative* treatment for gonorrhea for patients who cannot receive cephalosporins or for those who fail first-line therapy with ceftriaxone and azithromycin (but not those for whom reinfection, rather than true treatment failure, is suspected). The CDC recommends a test-of-cure 14 days after treatment for patients with pharyngeal GC infection who are treated with an alternative regimen. The combination of ceftriaxone 250 mg IM and 1 gram of oral azithromycin, both as single doses, remains the only first-line recommended regimen for treatment of uncomplicated gonorrhea in the U.S.[6].