County of San Diego Monthly STD Report

Issue No. 34: Data through October 31, 2011; Report prepared December 30, 2011.

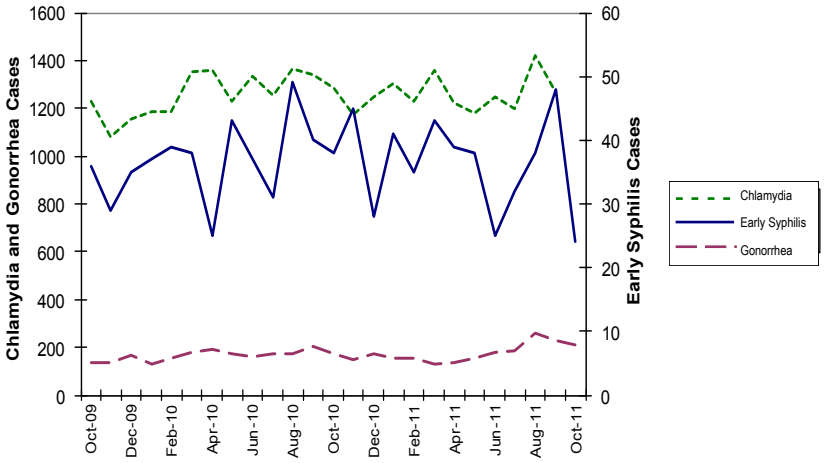
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Table 1. STDs reported among San Diego County residents, by month (October 2011), and year to date.

	2011		2010	
	Oct	*YTD*	*Oct*	*YTD*
Gonorrhea	207	1787	175	1704
Female age 18-25	30	284	31	278
Female age ≤ 17	5	50	3	31
Male rectal gonorrhea	44	299	31	265
Chlamydia*	1268	11434	1340	11614
Female age 18-25	566	5096	630	5199
Female age ≤17	84	814	79	858
Male rectal chlamydia	45	322	39	274
Early Syphilis (adult total)	24	363	37	370
Primary	5	94	7	76
Secondary	11	141	17	150
Early latent	8	128	13	144
Neurosyphilis**	0	3	0	5
Congenital syphilis	0	0	0	7
HIV Infection				
HIV (not AIDS)	47	401	40	414
AIDS	25	217	25	302

YTD: Year to Date
*Chlamydia data through September 2011 due to data entry delay, with comparison data through September 2010.
**Includes confirmed and probable cases of neurosyphilis among cases of early syphilis only.

Figure 1. Chlamydia*, early syphilis and gonorrhea cases reported among San Diego County residents, by month.**



*Chlamydia data through September 2011 due to data entry delay.
**Early syphilis includes primary, secondary and early latent syphilis.

Table 2. Selected STD cases and rates per 100,000 population for San Diego County by age and race/ethnicity, and year to date.

	(All races)		Asian/PI		African American		Hispanic		White	
	cases	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*	*cases*	*rate*
All ages										
Chlamydia*	11434	354.6	402	115.4	963	575.6	2397	242.8	1700	107.2
Gonorrhea	1787	55.4	58	16.6	206	123.1	279	28.3	406	25.6
Early syphilis	363	11.3	18	5.2	35	20.9	103	10.4	191	12.0
Under 20 yrs										
Chlamydia*	2619	298.4	54	64.5	301	610.8	685	192.5	300	89.0
Gonorrhea	203	23.1	5	6.0	42	85.2	38	10.7	23	6.8
Early syphilis	12	1.4	1	1.2	5	10.1	2	0.6	4	1.2

*Chlamydia data through September 2011 due to data entry delay.

Key Points, comparing reported cases in 2011 with 2010

- **Overall, chlamydia is stable, but….**
  - **Chlamydia in females ≤ 17 has decreased 5%.**
  - **Male rectal chlamydia has increased 18%.**
- **Overall, gonorrhea is stable.**
- **Overall, early syphilis is stable, but…**
  - **Primary syphilis is up 24%.**

Note: All data are provisional. Morbidity is based on date of diagnosis. If date of diagnosis is not available, date of specimen collection is used. Totals for past months might change because of delays in reporting from labs and providers.

Editorial Note: Three-Site Testing for Chlamydia (CT) and Gonorrhea (GC) in Men Who Have Sex with Men (MSM)

CT and GC infections may occur in the rectum or pharynx, often without symptoms, and will not be detected if only urogenital specimens are obtained. Appropriate risk assessment includes determining both the gender of a man's sex partners (MSM are disproportionately burdened by high rates of CT and GC infection) and the types of sex a man is having, to determine which body sites are at risk of infection.

Inflammatory STDs such as CT and GC increase the risk of acquiring and transmitting HIV. Case registry matching between State STD and HIV/AIDS databases has demonstrated a markedly higher incidence of CT and GC infections amongst HIV-infected persons compared with those not infected with HIV.

Data from a public STD clinic and gay men's health center in San Francisco in 2003 showed that 53% and 64% of CT and GC infections, respectively, would not have been detected had only urine/urethral testing been done. A similar analysis of male patients at San Diego County's Rosecrans STD clinic seen in 2010 showed that of men who had tests performed at multiple body sites and had at least one site positive, ***62% and 59% of CT and GC infections, respectively, would not have been detected had only urine/urethral testing been done***.

Steps to achieving standard-of-care CT and GC testing in MSM include:

1. Develop competence and comfort in obtaining a sexual history at initial visit and at routine intervals.
2. Use highly sensitive nucleic acid amplification tests (NAATs) for the detection of CT and GC.
3. Ensure that the laboratory utilized performs rectal and pharyngeal CT and GC NAAT testing, and know the billing codes required for such testing. CT and GC NAATs have not been FDA cleared for nongenital sites, however many laboratories in the county (including Quest and Labcorp) have performed internal validation, enabling them to offer these tests.
4. Self-collected anal NAAT specimens have been shown to have equivalent sensitivity as provider-collected specimens. If this approach is desired, make sure that staff knows how to instruct patients in performing this procedure. Examples of patient education posters:
   English: http://sfcityclinic.org/providers/RectalSwab_ENG.pdf
   Spanish: http://sfcityclinic.org/providers/RectalSwab_SPN.pdf
5. Recommend that sexually active MSM who are not in mutually monogamous relationships be screened for CT, GC and other STDs, including HIV, every 3 to 6 months.

Information about the County of San Diego STD Clinics: www.STDSanDiego.org
STD Clinical Consultation Pager: (877) 217-1816 (8 a.m.–5 p.m., M–F, except major holidays)
Provider STD Reporting: (619) 692-8520; fax (619) 692-8541
STD Clinic: (619) 692-8550; fax (619) 692-8543