County of San Diego

PHYSICIANS' BULLETIN

Health and Human Services Agency ◆ P.O. Box 85222, San Diego, CA ◆ 92186-5222 ◆ www.co.san-diego.ca.us/cnty/cntydepts/health

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STD Update For 2003

Syphilis

San Diego, like many large cities across the nation, is experiencing a resurgence of syphilis. During 2003, infectious syphilis (primary and secondary stage) increased >150% from 38 cases (1.3 per 100,000) in 2002 to 109 cases (3.7 per 100,000) in 2003. The increase occurred mainly among men who have sex with men (MSM) who accounted for 84% of cases in 2003 (Fig 1). The outbreak among MSM began late in 2002, peaked in Jan 2003, and has continued at a level of about 8 cases per month since then. Extrapolating from the cases reported from Jan – June 2004, an estimated 94 cases will be reported in 2004. **Of the MSM with syphilis in 2002 – 2003, 54% were also HIV infected.** However, almost half of MSM with syphilis were HIV negative at the time their syphilis was diagnosed. Some of these men may have acquired HIV at the same time but it was not yet detectable using routine HIV antibody testing.

During 2003, there were 10 cases of acute neurosyphilis reported; all were male. Case information about their presenting symptoms, HIV status, and follow-up is under investigation. In 2002 in San Francisco, among 340 HIV infected MSM with syphilis, 10 cases of acute neurosyphilis occurred. Among these, 3 had permanent sequela – total blindness, partial blindness and residual paralysis from meningovascular involvement. **These findings indicate that syphilis infection can be a very serious disease in HIV infected persons.**

We encourage physicians who provide care for MSM or HIV infected patients to keep **syphilis high on the differential diagnosis of any patient with a genital, anal/rectal, or oral ulcer (primary stage) or generalized body rash (especially on palms and/or soles) with adenopathy, hair loss, mucous patches, etc. (secondary stage).** For such patients we suggest ordering a screening test (RPR or VDRL), treating presumptively (2.4 million units of benzathine penicillin [Bicillin LA]), and reporting the suspect case by phone/fax to the STD Field Services section (see page 2). Investigators can provide assistance in getting patients treated and will offer partner services so that the exposed sex partners can be treated before they develop infectious syphilis. **We urge physicians to encourage patients with syphilis to cooperate with Health Department field investigators so that these services can be delivered and help prevent community transmission.**

Treatment information is available in the CDC's STD Treatment Guidelines available at **www.cdc.gov/STD/treatment/**. Algorithms (with photos of primary/secondary stage lesions) for evaluating possible syphilis are available upon request from the STD program (see page 2).

Gonorrhea

The upturn in gonorrhea that began in 2000, peaked in 2002 with 2128 cases, and was followed by a small (7%) decline to 1972 cases in 2003 (Fig 2). The male to female ratio in 2003 was 1.7 which suggests that MSM are acquiring gonorrhea disproportionately. A random survey of providers who reported patients with GC in 2001 showed that **at minimum 22% of total GC infections in the county were among MSM which equates to 433 MSM cases in 2003.** In addition, the number of male rectal/pharyngeal GC infections reported per year increased from an average of 37 cases per year from 1997 – 2000 to 120 cases per year 2001 – 2003, a 224% increase (Fig 3).

Data from the 2001 survey also showed that almost all rectal/pharyngeal cases were diagnosed in the County STD clinic and that about 40% of those persons had a negative urethral test which highlights the importance of culturing all exposed sites. Among MSM, relying only on urethral/urine testing will miss GC infections. In addition, recent data from San Francisco suggest that GC infection increases the risk of HIV acquisition among the MSM population even more than syphilis probably because many more MSM have GC than syphilis (estimated 433 GC vs. 92 syphilis in San Diego 2003).

We urge physicians to consider rectal/pharyngeal GC among MSM patients who are symptomatic and to screen asymptomatic MSM clients who have had an unprotected sexual exposure (anal or oral sex) in the past 2 months. GC cultures are the preferred method of screening, however, amplified testing is promising. GC cultures can be sent to private laboratories using appropriate transport media. The director of your clinical laboratory can provide the details for specimen handling.

The County STD clinics and main HIV counseling and testing site at 5th Ave. can perform oral and rectal GC culture screening.

Chlamydia

Chlamydia (CT) continues to increase in San Diego most likely because more screening is being done and providers are using amplified testing, which is more sensitive than other CT tests. However, the increase in 2003 was very slight (<1% increase from 10,225 cases in 2002 to 10,249 cases in 2003) (Fig 4). Most positives are among females (74%) because much more screening is done in this group compared to males.

Chlamydia continues to be an infection of adolescents and young adults (68% of cases). Routine universal screening, using urine amplified testing, of all adolescents admitted to juvenile detention over the last 7 years has shown that CT prevalence is relatively stable – among girls 12% and among boys 3%.

We urge clinicians to assess the risk of all young patients and to offer chlamydia (nucleic acid amplification test, NAAT) screening to all sexually active patients < 25 years of age annually, and anytime a patient reports acquiring a new sex partner since their last test.

Among females with CT infection, re-infection is common (~15% re-infection rate) **and re-screening is recommended at 8 – 12 weeks**. It is also important to encourage infected patients to inform their recent sex partners of the need to also be treated and, if possible, tested.

California Law allows physicians to prescribe/give CT medications to patients to deliver to their partner without the physician having a professional relationship with the partner. Alternatively, the partner can be tested, treated and receive a comprehensive STD evaluation at the County STD clinic (call 619-692-8550 for clinic location and hours).

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STD/Hepatitis Email Updates

STD/Hepatitis email bulletins are brief, time-sensitive updates that are sent 4 – 5 times per year. If you would like to receive the STD/HEP updates, please send an email to STDHEP.HHSA@sdcounty.ca.gov with "Join" in the subject line. You can also sign up by calling Craig Sturak, 619-692-8369, or by fax, 619-692-6651.

The *Physician's Bulletin* is published on an as-needed basis by the County of San Diego Health and Human Services Agency to provide updated information on health issues of concern to San Diego County's medical community.

Fig 1

Primary & Secondary Syphilis
MSM and Other Cases by Year of Report
San Diego 1995-2003

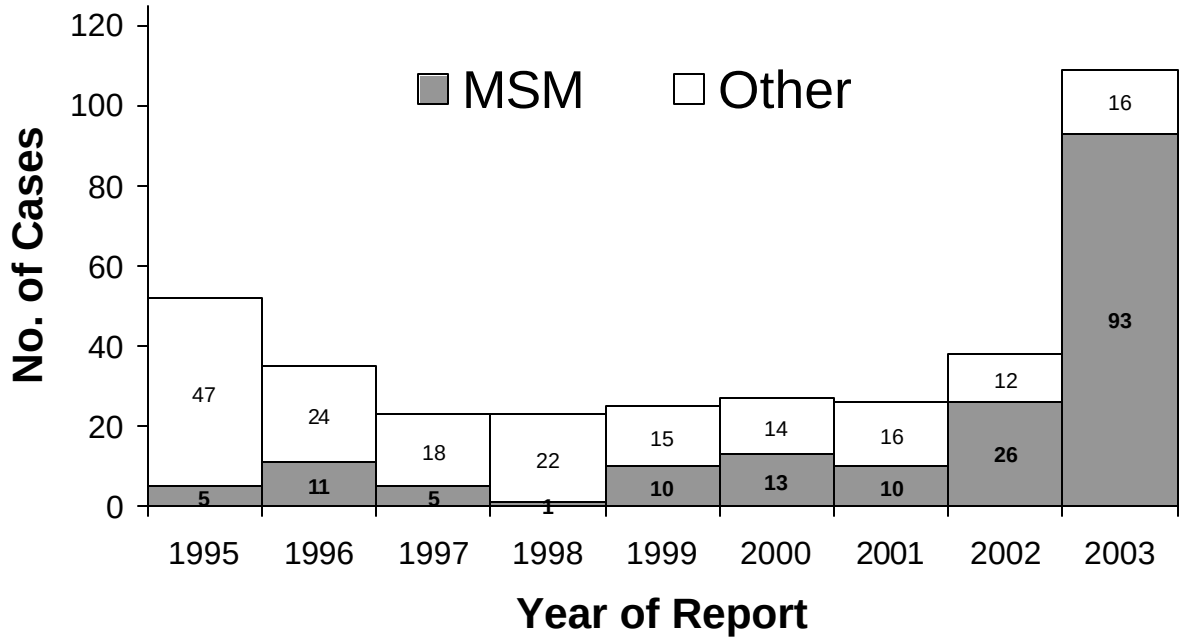

Fig 2

Gonorrhea Cases by Year, San Diego 1993-2003

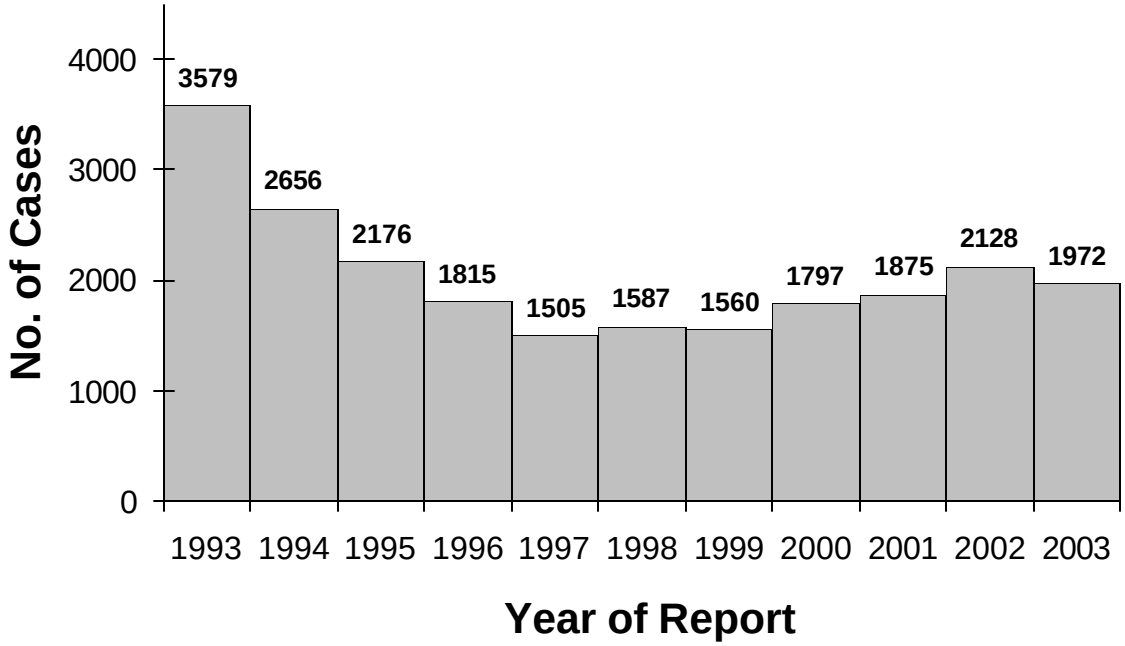

Fig 3

Reported Rectal or Pharyngeal GC Infections Males, San Diego 1997-2003

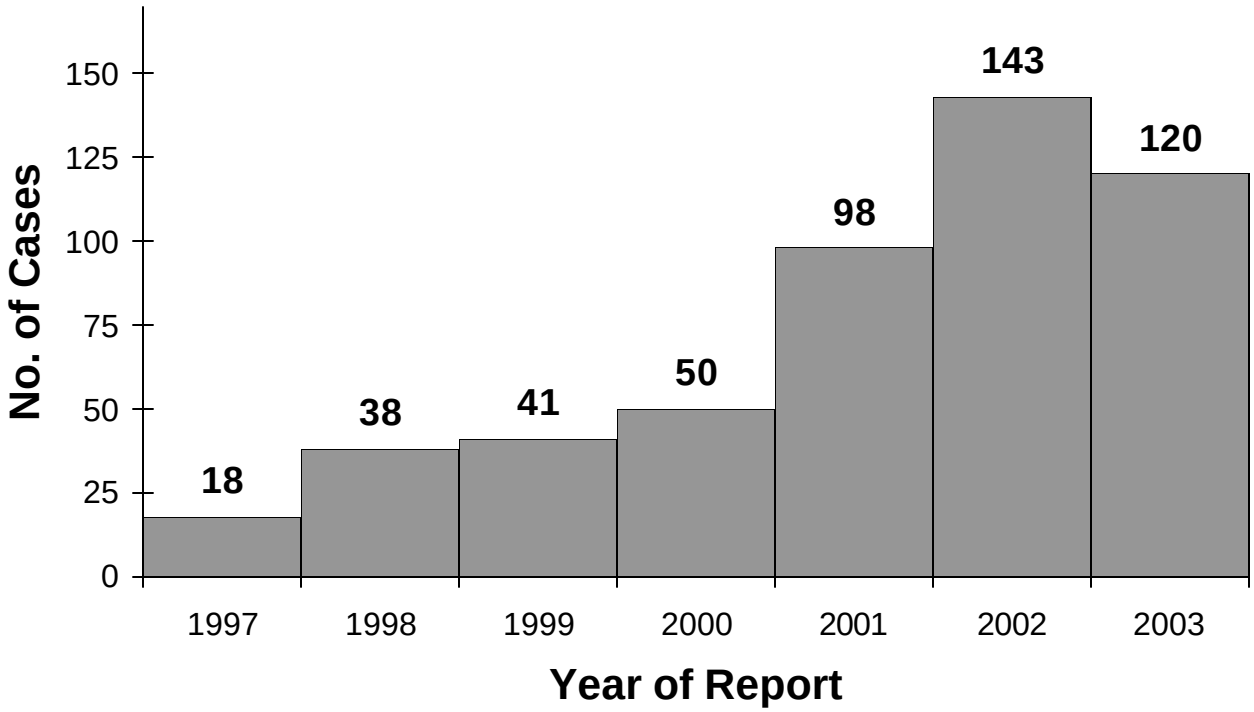

Fig 4

Chlamydia Cases by Year, San Diego 1993-2003