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 2004

Syphilis

San Diego, like many urban areas across the nation, continues to experience a resurgence of syphilis. During 2004, infectious syphilis (primary and secondary stage) increased 25% from 109 cases (3.7 per 100,000) in 2003 to 136 cases (4.5 per 100,000) in 2004. The combined annual rate for 2003–2004 (4.1 per 100,000) was > 3 times greater than the rate for 2001–2002 (1.1 per 100,000) (Fig. 1). The projected annual number of cases for 2005 is up another 61% to 219 infectious syphilis cases based on the number of cases reported during January–April 2005.

In 2004, reported cases have been mainly among men who have sex with men (MSM) who accounted for 76% of cases. However, 16 cases were identified among heterosexuals that were related to gang activities and methamphetmine use. Methamphetamine use is common among persons with syphilis being reported in 34% of total cases in 2004. In 2005, heterosexual transmission is continuing especially among Latinos in East County San Diego. HIV infection among syphilis cases was common with 54% of all cases being HIV positive and among MSM 67% were HIV positive. Control of syphilis among MSM is important because syphilis infection facilitates the transmission of HIV.

The most infectious stage of syphilis occurs during the primary stage when a syphilitic ulcer is present (usually painless and lasts three–four weeks before spontaneously healing). Among MSM, 64% of cases were diagnosed in the secondary stage indicating that the most infectious primary stage was not diagnosed or treated. The syphilitic ulcer may have been present and unnoticed in the rectum/anal canal or in the oral cavity. Frequent syphilis serologic screening, as often as every 3 months, for high-risk MSM who have many sex partners, is recommended.

We encourage physicians who provide care for MSM, HIV infected patients or high–risk heterosexual 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 or oral mucous patches (secondary stage).** For such patients we suggest a serologic 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 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 has continued with 2,376 cases (78.7 per 100,000) reported in 2004 which is a 20% increase over 2003 (1,972 cases; 67 per 100,000) and a 52% increase since 1999 (Fig. 2). The male to female ratio in 2004 was 1.5, which suggests that MSM are acquiring gonorrhea disproportionately. A random sample survey in 2001 of providers who reported pa-

tients with GC showed that **at minimum 22% of total GC infections in the county were among men who have sex with men** which equates to an estimated 522 MSM with GC in 2004. 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 130 cases per year 2001–2004, a 250% increase (Fig. 3).

A recent review of GC testing by site of specimen collection among MSM STD clinic clients in San Diego covering the years 1997–2003, showed that among 7,333 MSM clients tested for GC, 1,157 (15.8%) were positive including 510 with a rectal/pharyngeal positive GC test. Among 494 with a positive rectal/pharyngeal GC test, who also had a urethral test done, the urethral test was negative for the 369 (75%). Thus, had the STD clinic not done a rectal or pharyngeal culture and relied only on the urethral test results, 32% (369/1157) of the GC infections would have been missed.

GC cultures are available at most major laboratories serving San Diego County. We encourage clinicians to obtain rectal and/or pharyngeal GC cultures from MSM who report exposure at these sites during the past two months or refer patients to a provider where GC culture is available such as the County STD Clinic. Rectal, and especially pharyngeal, GC is usually asymptomatic and rectal GC very likely facilitates HIV transmission.

Chlamydia

Chlamydia (CT) continues to increase slightly in San Diego most likely because more screening is being done and providers are using nucleic acid (DNA/RNA) amplified testing (NAAT), which is more sensitive than other CT tests. In 2004, 10,822 cases were reported (359 per 100,000) which is a 5.6% increase from the 10,249 (346 per 100,000) reported in 2003 (Fig. 4). Most positives are among females (73%) because much more screening is done in this group compared to males.

Chlamydia continues to be an infection of adolescents and young adults (66% of cases). Routine screening, using urine amplified testing, of all adolescents admitted to Juvenile Detention in San Diego over the last 6 years (1998–2003) has shown that CT prevalence was relatively stable – among females 12% and among males 3%. However, in 2004 prevalence among females increased to 16% (222/1374 screened).

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 females < 25 years of age annually, and to all high-risk males < 25 (i.e. multiple partners, prior STDs, drug abuse).

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 all infected patients to inform their recent sex partners of the need to also be treated and, if possible, tested. Because of the large number of patients with chlamydia and gonorrhea, the STD Field Program is unable to provide partner follow-up services for persons with these infections and we rely on providers to work with their patients to inform partners of their need to be treated. 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 locations and hours).

Contact Information

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STD/Hepatitis Admin: 619-692-8082; fax 8313
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STD/Hepatitis Email Updates

If you would like to receive STD/HEP email 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 *Physicians' 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 1995-2004

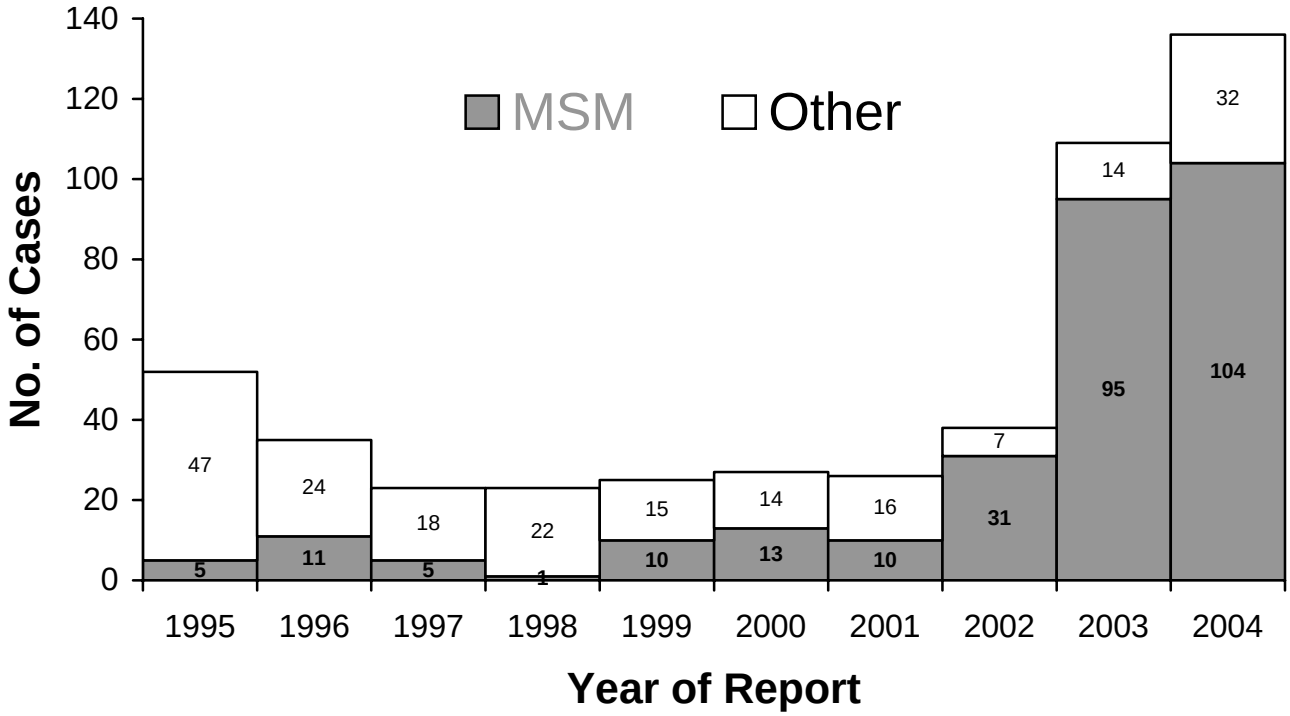

Fig 2

Gonorrhea Cases by Year, San Diego 1993-2004

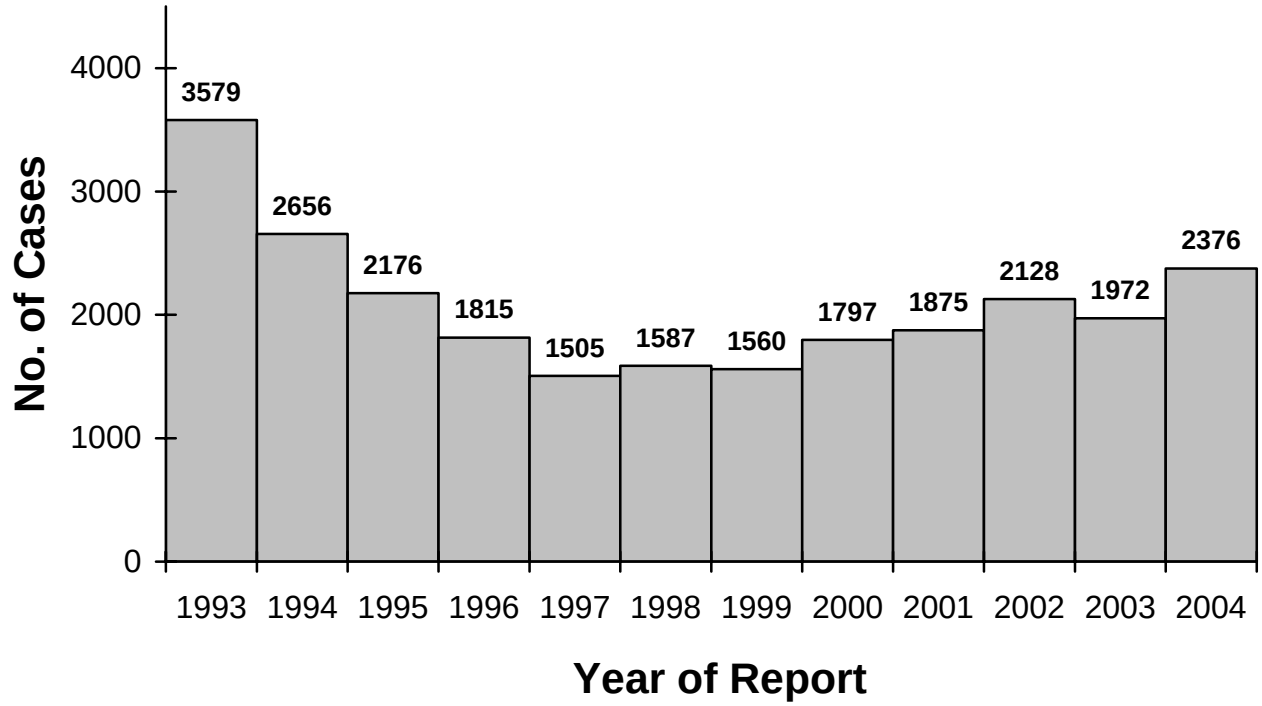

Fig 3

Reported Rectal or Pharyngeal GC Infections Males, San Diego 1997-2004

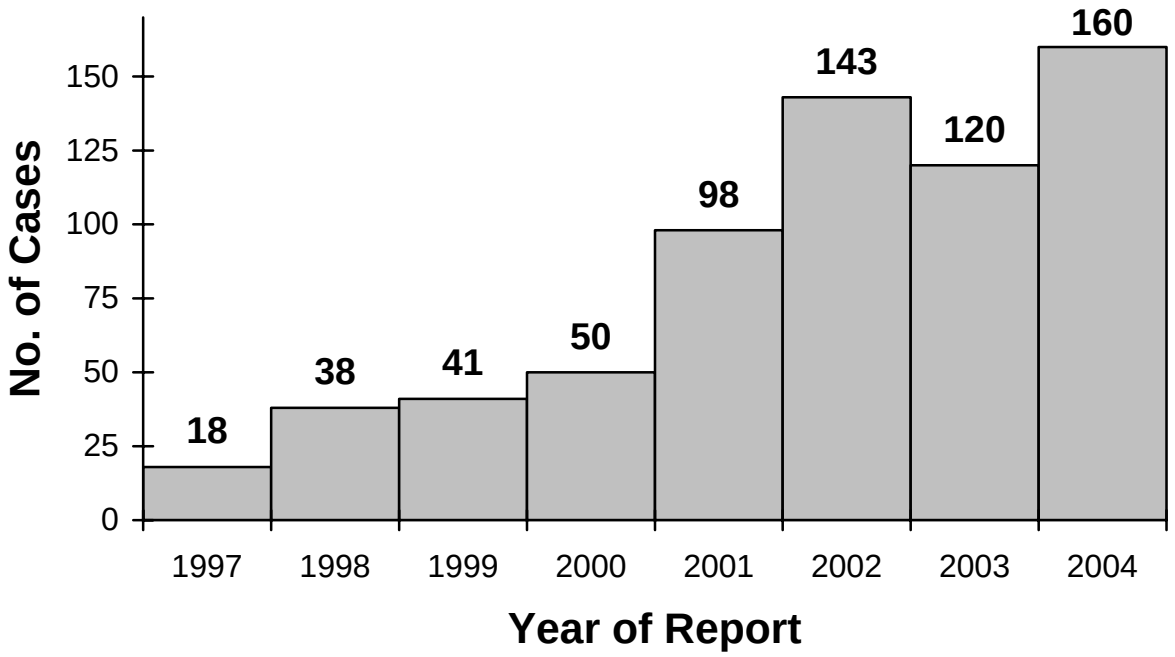

Fig 4

Chlamydia Cases by Year, San Diego 1993-2004