



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Disease Bulletin

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(Leprosy)

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CDC Updates STD Treatment Guidelines

The Centers for Disease Control and Prevention (CDC) has updated guidelines for the treatment of sexually transmitted diseases (STDs), which were last published in 2006: www.cdc.gov/mmwr/preview/mmwrhtml/rr5912a1.htm?s_cid=rr5912a1_w.

Notable changes are highlighted in the box. General topic areas included in the guidelines are outlined below.

Education

The guidelines outline the use of high-intensity behavioral prevention counseling for all sexually active adolescents and adults at increased risk for STDs and HIV based on recommendations published in 2008 by the United States Public Health Task Force. Prevention counseling is an interactive approach to determine the patient's personal risk factors and work with them to reduce their risk. Prevention counseling is most effective if delivered in "a non-judgmental and empathetic manner appropriate to the patient's culture, language, sex, sexual orientation, age, and developmental level."

Prevention Methods

The guidelines include the latest CDC

vaccine recommendations for hepatitis B virus, human papilloma virus (HPV), and hepatitis A virus. Both the bivalent Cervarix® and quadrivalent Gardasil® HPV vaccines are recommended for adolescent and young adult females in the appropriate age groups for cervical cancer prevention. Gardasil®, with its quadrivalent composition covering the most common cancer-causing and wart-causing HPV types, can also be used with both males and females aged 9–26 years to prevent genital warts.

A section addressed male circumcision for reducing risk of male heterosexual acquisition of HIV and certain other STDs. The guidelines cite studies performed in Sub-Saharan Africa that demonstrate male circumcision reduced the risk for HIV acquisition among men by 50–60%; however, these results have not been demonstrated for men who have sex with men (MSM), and recommendations for male circumcision as a risk-reduction measure in the United States remain under review.

Special Populations

Recent studies indicate that some women who have sex with women (WSW) might be at increased risk for STDs and HIV. HPV has

been demonstrated to be transmitted between women during sex. All women, regardless of sexual preference, should be offered HPV vaccine in accordance with current guidelines. Bacterial vaginosis (BV) is more common among women with female partners than among women in general; however, routine screening for BV or

Notable changes in the recommended or alternative therapy for STDs.

- Increased ceftriaxone dosage for gonorrhea: 250 mg IM in a single dose should now be used for cervical, urethral, rectal, or pharyngeal gonorrhea infection in adolescents and adults. Quinolones should not be used.
- Additional treatment for non-gonococcal urethritis (NGU): NGU due to *Mycoplasma genitalium* can be effectively treated with 400 mg moxifloxacin orally once daily for 7 days.
- Additional treatment option for episodic herpes outbreaks: 500 mg famciclovir orally once, followed by 250 mg twice daily for 2 days. Other primary, episodic, or suppressive therapies are described.
- New patient-applied treatment for genital warts is available: sinecatechin 15% ointment 3 times daily until cleared.
- New alternative regimen for bacterial vaginosis: 2 g tinidazole orally once daily for 2 days, or 1 g orally once daily for 5 days.

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treatment of partners of women with BV is not recommended.

The incarcerated population has exploded in size in the last three decades, and with the United States prison population nearly 2.3 million persons in 2009, it may not be surprising that a new Special Populations section focusing on persons in correctional facilities was added. The guidelines state persons entering correctional facilities have higher rates of STDs and viral hepatitis, and many had limited access to medical services prior to incarceration. This section recommends universal screening at intake for chlamydia and gonorrhea for all adolescents, and for adult females up to 35 years of age (or on the basis of local institutional prevalence). Universal screening for syphilis should be conducted based on local epidemiology and institutional prevalence of early infectious syphilis. See the article "Update on STDs in Idaho" included in this issue of Idaho Disease Bulletin describing the latest Idaho syphilis data.

Chlamydia and Gonorrhea

Chlamydia management recommendations remain largely unchanged.

The ability of *Neisseria gonorrhoea* to develop antimicrobial resistance has led to a single class of drugs now available for the reliable treatment of gonorrhea: cephalosporins. Quinolones have not been recommended since 2007. The recommended ceftriaxone dosage has been increased to 250 mg IM in a single dose for uncomplicated gonorrhea infection in adults or adolescents. Ceftriaxone at the recommended dosage is effective in curing uncomplicated gonorrhea in all anatomic sites. Clinicians should be aware that other antimicrobial regimens listed as therapies for uncomplicated urogenital or anorectal gonorrhea infection are less reliable for curing pharyngeal infections and are not recommended.

Nucleic acid amplification tests (NAATs) are the most reliable tests to detect pharyngeal or rectal infection, but because this use is not FDA-approved, the testing must be performed by a laboratory which has validated the method for these specimens, such as the Idaho Bureau of Laboratories. A list of public health

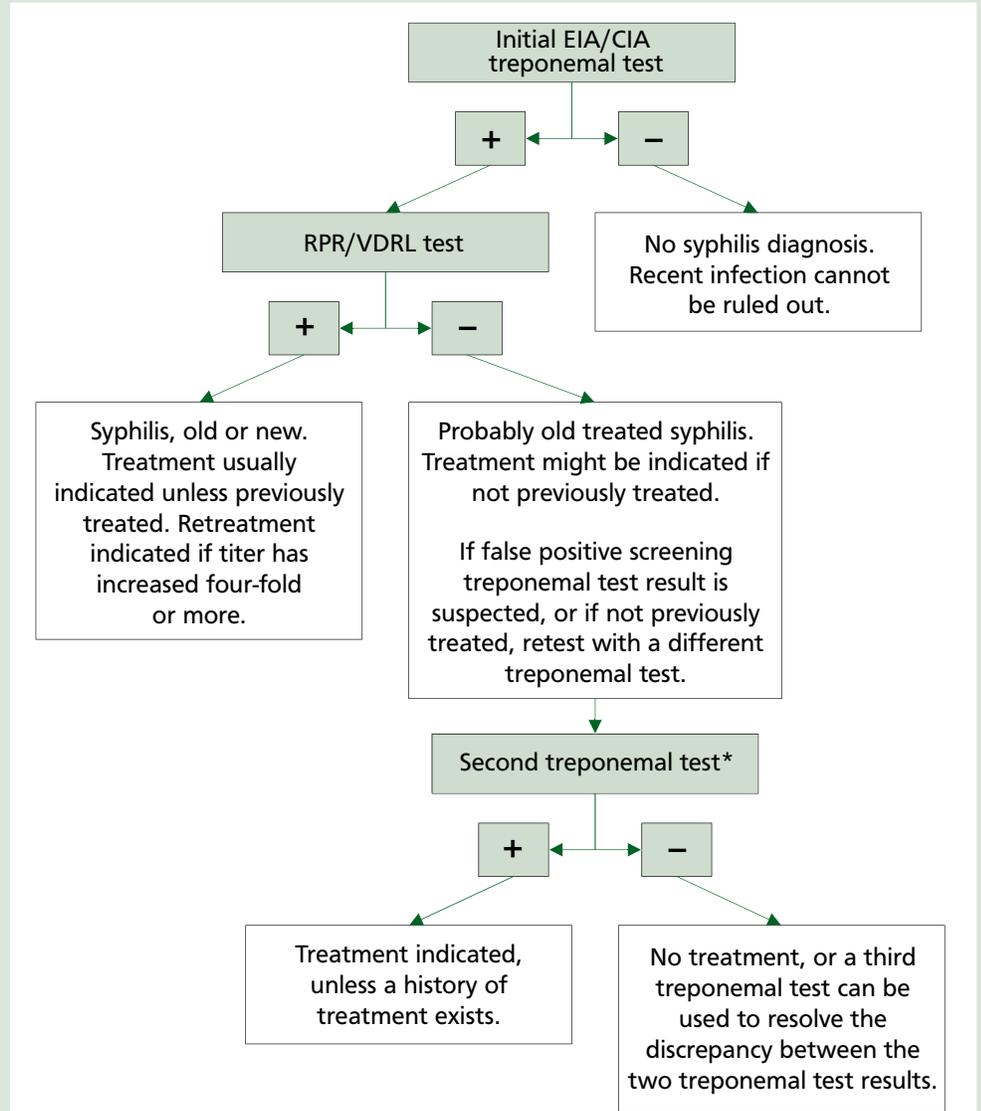
laboratories that can perform these tests is available at: www.aphl.org/aphlprograms/infectious/std. Private laboratories that perform the tests and have validated their methods are noted at: www.cdc.gov/std/general/dcl-ng-ct-testing-7-13-2009.pdf. The proper ordering codes may be obtained from www.stdcheckup.org/provider/screen_testing.html. Culture remains the preferred method for diagnosis in prepubertal children.

Reinfection rates after detection and successful treatment of uncomplicated urogenital chlamydia or gonorrhea infection range from 7–24%. Therefore,

rescreening at 3–6 months to detect reinfection is recommended. Rescreening is distinct from test of cure. Test of cure is usually done 3–4 weeks after treatment for the purpose of detecting treatment failure and is not necessary when using any of the recommended or alternate chlamydia and gonorrhea regimens with uncomplicated infections.

Patients with detected chlamydia or gonorrhea should refer sexual contacts from 60 days prior to onset of symptoms (or diagnosis, if asymptomatic) for evaluation and treatment. Patient-delivered partner therapy (PDPT), synonymous

Figure. Algorithm for interpretation of syphilis test results using EIA/CIA as the initial screening test.



Adapted from: Centers for Disease Control and Prevention. Syphilis Testing Algorithms Using Treponemal Tests for Initial Screening — Four Laboratories, New York City, 2005–2006. *MMWR* 2008;57:872–875 and Centers for Disease Control and Prevention. Discordant results from reverse sequence syphilis screening—five laboratories, United States, 2006–2010. *MMWR* 2011;60:133–137.

**Treponema pallidum* particle agglutination (TPPA) or fluorescent treponemal antibody (FTA) tests. Because FTA-ABS has lower specificity and probably lower sensitivity, in addition to inherent subjectivity and the need for trained personnel and a dedicated fluorescence microscope, TPPA is considered the most suitable confirmatory test.



with Expedited Partner Therapy (EPT), should be considered for heterosexual partners if there is a concern that partners referred to evaluation and treatment will not seek these services. PDPT or EPT is not recommended for MSM; because of the possibility of coinfection with other STDs or HIV, MSM should receive front-line evaluation.

Syphilis Screening Tests

Although CDC continues to recommend the traditional algorithm of

screening¹, in recent years, large reference laboratories' preference of syphilis screening tests has shifted to enzyme immunoassays (EIAs). EIAs and chemiluminescence immunoassays (CIAs) to detect *Treponema pallidum* antibody are more automated and less costly to perform than rapid plasma reagin (RPR) titers at many large laboratories. A positive result from the EIA cannot distinguish between old, previously treated, or new infection. Clinicians should seek a quantitative reflexive RPR/Venereal Disease

Research Laboratory test result (titer) and possibly a second treponemal test² to guide management. See the algorithm (Figure) for help with interpreting results using EIA/CIA as the initial screening test. 

Footnotes

¹ The traditional algorithm uses non-treponemal tests (Venereal Disease Research Laboratory [VDRL], rapid plasma reagin [RPR]) followed by confirmation using treponemal tests.

² *Treponema pallidum* particle agglutination (TPPA) or fluorescent treponemal antibody (FTA) tests.

Update on STDs in Idaho

Sexually transmitted diseases (STDs) are a continuing burden on Idaho residents and medical resources. STDs are among the most frequently reported of all Idaho reportable diseases. Monitoring the trends and characteristics of effected populations and communicating the results can help improve programs aimed at preventing STDs and health care providers' understanding of the scope of the burden to make informed decisions about testing, treatment, and counseling of patients. This article aims to effectively communicate information about some notable emerging patterns in Idaho STDs: recent increases in gonorrhea and early syphilis among men who have sex with men (MSM).

In 2010, there was an increase in reports of gonorrhea after two years of significant decline. From a high of 269 cases in 2007, counts returned to baseline in 2009 with 110 cases. In the last quarter of 2010, however, gonorrhea cases increased substantially, pushing the 2010 rate 30% over the rate in 2009 (Figure). Most of the 4th quarter increase in 2010 was in Central public health district which had a 230% increase over the average quarterly number of reportable cases since 2009. Notable increases were also observed in North Central and Southwest public health districts.

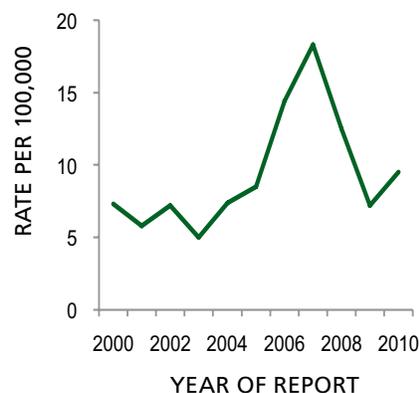
Although the total number of reported syphilis cases decreased in 2010, the number of those cases classified as early syphilis (primary, secondary, or early latent syphilis) increased. Cases were spread

widely across age groups. Nine of the ten cases of recently-acquired syphilis occurred in males, all of whom reported having sex with other males (MSM). Five had HIV coinfection, which serves to remind clinicians that individuals with syphilis infection should also be tested for HIV, and vice versa. This distribution is similar to CDC's STD Surveillance Network trends, where over half of primary and secondary syphilis is reported among MSM and a median 44.4% HIV coinfection exists among MSM reported with primary and secondary syphilis. One case of congenital syphilis was reported, an uncommon but nevertheless troubling occurrence. There is some disparity in regard to ethnicity: 9 (53%) of 17 reported syphilis cases for which ethnicity was known occurred among persons of Hispanic ethnicity, although

only 11% of Idaho's population self-identifies as Hispanic or Latino.

Please note that these preliminary data have been provided in the interest of increasing awareness of the scope, distribution, and basic epidemiologic characteristics of recently-reported STDs in Idaho. Office of Epidemiology, Food Protection, and Immunizations will publish more detailed tables of finalized 2010 data in the annual publication, "Idaho Reported STD" later this year. The current version, containing 2009 data, is available on the Idaho Department of Health and Welfare web site by going to www.safesex.idaho.gov and clicking on "STD Statistics" on the left side of the screen. 

Figure. Incidence rate of reported gonorrhea in Idaho, 2000–2010.*



*Per 100,000 population. 2010 data are preliminary.

Idaho Disease Bulletin Now Available Electronically— See Our New IDB Website!

In January 2011, the Idaho Disease Bulletin (IDB) website (www.IDB.dhw.idaho.gov) was redesigned to include searchable indices of issues from the last 10 years, the ability for you to suggest topics, and the ability for you to sign up to receive an electronic copy of the IDB. Electronic distribution of the IDB is a new feature this year. If you would like to receive a link to new issues of the IDB by e-mail please go to www.IDB.dhw.idaho.gov to submit a request or send an email to IDB@dhw.idaho.gov.



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An electronic version of the Rules and Regulations Governing Idaho Reportable Diseases may be found at <http://adm.idaho.gov/adminrules/rules/idapa16/0210.pdf>.

Current and past issues are archived online at www.idb.dhw.idaho.gov.

Data Snapshot: Hansen’s Disease (Leprosy)

Hansen’s disease (leprosy) is a chronic, bacterial infectious disease caused by *Mycobacterium leprae* and mainly affects the skin, peripheral nerves, mucosa of the upper respiratory tract, and eyes. Treatment with multiple antibiotics including rifampin, dapson, and sometimes clofazimine is effective. Duration of treatment is up to 24 months, depending on whether the infection is paucibacillary (shorter treatment) or multibacillary (longer treatment). Hansen’s disease has become increasingly rare in the United States. Since the mid-1990s, fewer than 200 cases per year have been reported in the United States, mostly from California, Florida, Hawaii, Texas, and New York City. Most cases reported in the United States are in foreign-born persons. In Idaho, only 12 cases have been reported since 1975. In 2010, Idaho was contacted by another state to report that a child aged 11 years who had multibacillary Hansen’s

disease was moving to Idaho. This child is currently completing a two-year regimen of antibiotics under the care of an Idaho physician. 🏠

Figure. Reported Hansen’s disease (leprosy) cases by year—Idaho, 1975–2009.

