Sexually Transmitted Infections

Santa Cruz County

July 2014

All reportable sexually transmitted infections (STIs) are increasing among Santa Cruz County residents (Table 1). **Medical providers and laboratories are legally mandated to report these infections to the Local Health Department.**

http://www.santacruzhealth.org/phealth/cd/3reportingguidelines.htm

If You Don't Ask, They Won't Tell

Take a sexual history routinely as part of the clinic visit. Briefly assess the number and gender of sexual partners, history of STIs, and sexual practices (i.e. vaginal, anal and oral sex).

The national recommendation is to screen all sexually active women <25 years old at least annually. Screen other patients according to risk factors: current pregnancy, history of STIs, new or multiple sex partners, partner with other partner(s), men who have sex with men, commercial sex workers, and methamphetamine users.

SYPHILIS ~ The Great Imitator

Any new onset of a macular, papular, or squamous rash should warrant a nontreponemal test (RPR/VDRL). If positive, confirm with a treponemal test (FTA-ABS/TPPA). This is virtually always positive in secondary syphilis. If clinical suspicion is high for syphilis and the serological tests are negative, then a biopsy of the lesion or rash is recommended.

There has been a striking increase of infectious syphilis since 2010 among Santa Cruz County residents. This year, 25 cases have been reported as of July 15th. Since 2011, our rate has surpassed national levels (Figure 1).

In 2013, over half of the cases were under age 35 (Table 2), compared to one-quarter of cases under age 35 in 2012. This may explain the lower HIV co-infection in 2013, 31% versus 57% in 2012. Of concern, genital sores caused by syphilis make it easier to transmit and acquire HIV infection. There is an estimated 2- to 5-fold increased risk of acquiring HIV when syphilis is present (CDC). HIV screening should be included with syphilis testing.

LOCAL SYPHILIS CONTROL ASSISTANCE

Paula Haller, PHN, NP, STD Coordinator at **(831) 454-4114,** can search for past syphilis test results and treatment as needed; she can access local and state syphilis registries.

Table 1 -- Case Counts by Condition, Santa Cruz County, 2012 and 2013

Disease	2012 Cases	2013 Cases	Change
Syphilis*	28	32	↑
Gonorrhea	99	134	↑
Chlamydia	868	1,003	↑

*Includes primary, secondary and early latent stages of syphilis

Figure 1 -- Infectious Syphilis Rates by Year of Diagnosis, United States, 2008-2012, California and Santa Cruz County, 2008-2013

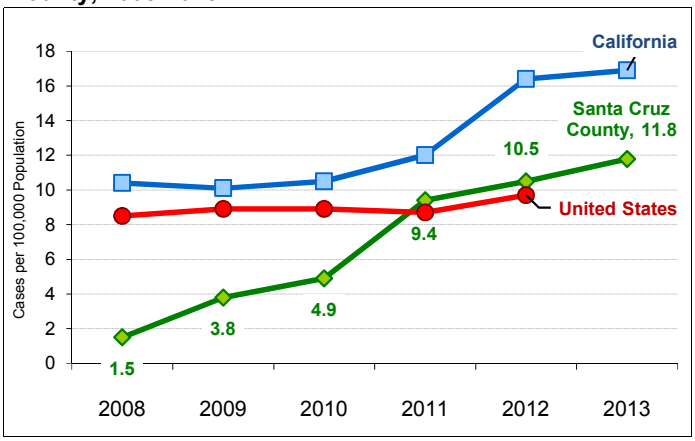

Table 2 -- Characteristics of Infectious Syphilis Cases (n=32), Santa Cruz County, 2013

	Count	Percent
SEX		
Male	31	97%
Female	1	3%
AGE		
Under 25	7	22%
25 - 34	10	31%
35 - 49	10	31%
50 and Over	5	16%
ETHNICITY		
Latino	16	50%
White	13	41%
Other	3	9%
HIV STATUS		
Positive	10	31%
Negative	20	63%
Unknown	2	6%
SEXUAL ORIENTATION		
MSM *	27	84%
Heterosexual	5	16%
HAS ANONYMOUS SEX PARTNERS		
Yes	11	34%
No	17	53%
Unknown	4	13%

* MSM: men who have sex with men (includes bisexual men)

GONORRHEA ~ Don't Resist

Santa Cruz County Gonorrhea (GC) rates increased **35%** from 2012 to 2013 (Figure 2). GC has become resistant to all but one class of antibiotics: cephalosporins. In some parts of the world, we are seeing decreasing susceptibility of gonorrhea to cephalosporin antibiotics. For this reason, the current California STD and CDC guidelines recommend **concurrent dual antibiotic therapy** to improve treatment efficacy and prevent the emergence of antibiotic resistance:

Ceftriaxone 250 mg. intramuscular (IM)

plus, either

Azithromycin 1 gm orally in a single dose *or*

Doxycycline 100 mg orally twice a day for 7 days

A California Department of Public Health review of GC treatment practices revealed providers were often under-treating patients because they were presumptively treating for chlamydia or non-gonoccocal urethritis using single antibiotic therapies. Later when positive lab results showed gonorrhea, the patients were brought back and only treated with IM ceftriaxone -- which is not adequate. Treatment needs to be concurrent in order to allow different mechanisms of action to treat other organisms which have potential to develop resistance.

MEN WHO HAVE SEX WITH MEN (MSM)

For MSM patients, identify the sites of sexual exposure (pharyngeal/rectal/urogenital) and test accordingly. Do not site test according to symptoms, as patients are often asymptomatic from infected extragenital sites. In a retrospective analysis of asymptomatic MSM in San Francisco, 84% of extragenital chlamydia and gonococcal infections were missed by urethral screening alone. Extragenital screening is critical in this population (Marcus, et al., 2011).

CHLAMYDIA ~ A Missed Opportunity?

The CDC recommends re-testing female patients 3 months after treatment, and empirically treating all sexual partners from the previous 2 months to avoid re-infection. In 2013, the highest chlamydia rate was among Santa Cruz County females ages 20-24 years (Figure 5).

RESOURCES

California Department of Public Health, STD Guidelines

http://www.cdph.ca.gov/pubsforms/Guidelines/Pages/SexuallyTransmittedDiseasesScreeningandTreatmentGuidelines.aspx

CITATIONS

Marcus JL, Bernstein KT, Kohn RP, Liska S, Philip SS. Infections Missed by Urethral-Only Screening for Chlamydia or Gonorrhea Detection Among Men Who Have Sex With Men. Sex Transm Dis 2011; 38(10):922-924.

Figure 2 -- Gonorrhea Rates by Year of Diagnosis, United States, 2008-2012, California and Santa Cruz County, 2008-2013

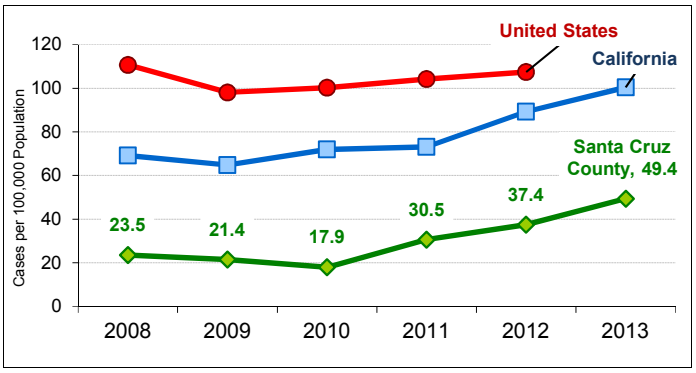

Figure 3 -- Gonorrhea Rates by Gender and Age Group, Santa Cruz County, 2013

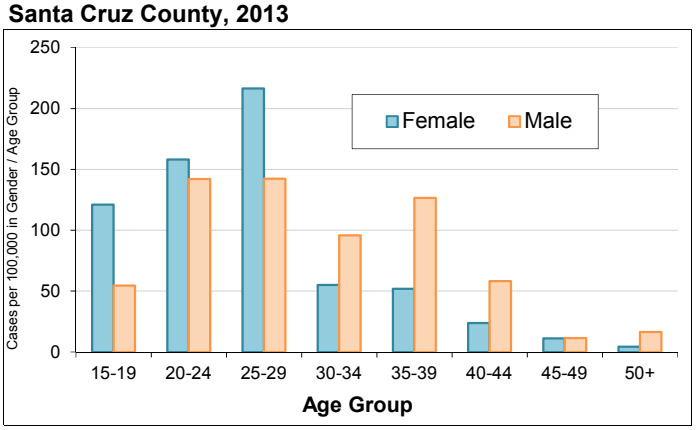

Figure 4 -- Chlamydia Rates by Year of Diagnosis, United States, 2008-2012, California and Santa Cruz County, 2008-2013

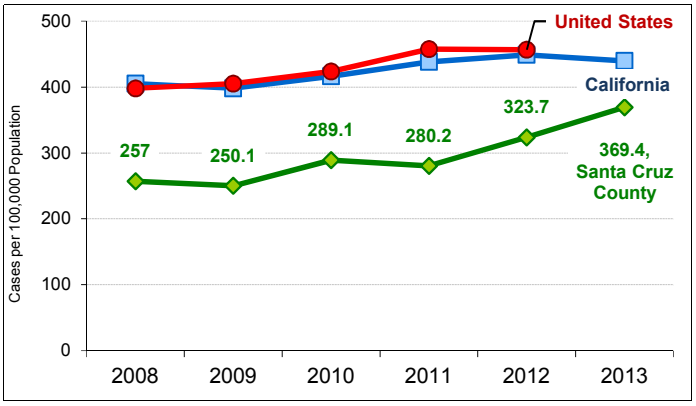

Figure 5 -- Chlamydia Rates by Gender and Age Group, Santa Cruz County, 2013