Marion County
OREGON
Health & Human Services

1st Quarter April 2018

To report a communicable disease
(24 hours a day, 7 days a week)
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Sexually Transmitted Infections Update in Marion County

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This report contains preliminary data that is subject to change

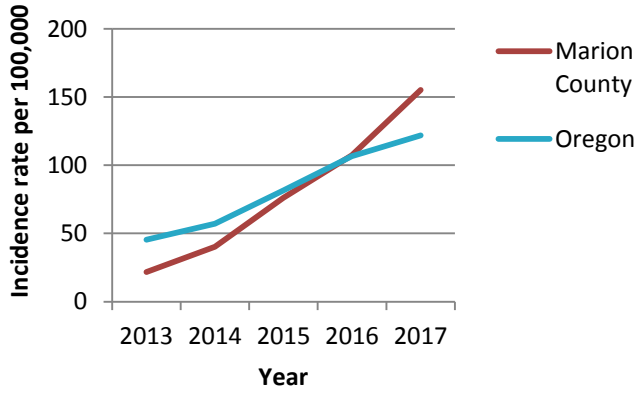
	Year to date	Year Total
	2018	**2017**
BIRTHS		
TOTAL DELIVERIES	1143	5049
Delivery in Hospital	1110	4950
Teen Deliveries (10-17 years)	12	79
DEATHS		
TOTAL	749	2908
Homicide	0	15
Suicide	9	49
Accident – Motor Vehicle	0	26
Infant Deaths	1	14
Fetal Deaths	0	14
COMMUNICABLE DISEASES		
Chronic Hep. B	8	38
Hepatitis C	102	471
Tuberculosis	7	6
SEXUALLY TRANSMITTED DISEASE		
Chlamydia	457	1669
Gonorrhea	133	525
Syphilis	20	123
HIV/AIDS	7	17

Report available online visit

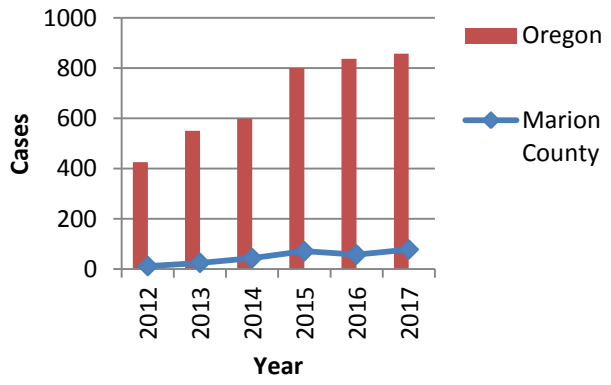
http://www.co.marion.or.us/HLT/PH/Epid/Pages/quarterlyreports.aspx

Seeing a lot of sexually transmitted infections? April is Sexually Transmitted Disease Awareness Month and the news is not good. Sexually transmitted infections (STIs) are at a record high in the U.S. For the third year in a row, rates of chlamydia (CT), gonorrhea, (GC), and syphilis have all increased nationally. The number of syphilis cases reported has doubled in Oregon and increased by more than 6 times in Marion County since 2012. Gonorrhea cases continue to spiral higher with a jump of more than 600% in Marion County and 168% in Oregon since 2013. (See graphs). Clinician's daily interactions with patients are critically important in treating and preventing these infections. The Centers for Disease Control and Prevention (CDC)has chosen **Treat Me Right** as their theme for STD Awareness Month in 2018. For providers, 'Treat Me Right' is an opportunity to ensure they have the needed tools to detect and treat infections appropriately.

Gonorrhea incidence rate per 100,000, 2013-2017



Syphilis Cases in Marion County & Oregon 2012-2017



Here's the top 10 list of what you need to know to impact STIs in your practice and our community

1. Take a sexual history to identify risks.

A sexual history includes questions about the 5 Ps and will inform your screening decisions for that patient.

- ○Partners – number and gender
- ○Practices – oral, rectal, vaginal
- ○Past History of STIs – HIV, syphilis, gonorrhea
- ○Pregnancy prevention – contraception if any
- ○Protection from STIs – frequency of condom use

2. Screen by age and risk factors.

Routine screening for common STIs is indicated for sexually active adolescents and young adults as STI rates are disproportionately higher in these populations. Syphilis and HIV frequently occur together because of associated risk factors.

- ○Women less than 25 years of age - CT and GC testing at least annually.
- ○Men who have sex with men (MSM) - GC, HIV, and syphilis at least annually.
- ○High risk MSM (multiple, anonymous partners, on HIV pre-exposure prophylaxis, PReP) - GC, HIV, syphilis every three months
- ○Pregnant women – HIV and syphilis at first prenatal visit, syphilis at 28 weeks, and at delivery
- ○All patients getting an HIV test should be screened for syphilis and vice versa.

3. Screen all potentially exposed anatomic sites.

Studies have demonstrated that sexually transmitted infections at extragenital sites are less likely to be detected through urethral screening alone. **All** sites including orapharyngeal and rectal sites should be tested if patient reports exposure in those locations. (See 1, Practices above).

4. Syphilis testing is dependent on past history of infection.

Enzyme immunoassays and chemiluminescent assays (EIA/CIA) are treponemal tests. Treponemal tests, once positive, will always remain positive and cannot be used to screen or monitor for new syphilis infections in patients with a prior history of syphilis. These patients must be screened with a quantitative RPR. (See 1, Past History above).

5. Treatment for syphilis is dependent on staging.

Patients diagnosed with syphilis must be staged to receive appropriate treatment. Changes to staging language took effect on January 1, 2018. These include a designation of early syphilis as primary, secondary, and onset within past year (by serology or symptoms) and late syphilis as onset of greater than a year ago or unknown duration.

- ○Early syphilis is treated with **2.4 million units of intramuscular (IM) Benzathine (long-acting) penicillin (Bicillin)**.
- ○Late or unknown duration syphilis is treated with **7.2 million units of IM Bicillin divided into 3 weekly doses**.

6. Follow treated syphilis patients with quantitative RPR at 3-6 month intervals depending on risk factors.

- ○Effective treatment is measured by a 4-fold decline in the RPR titer.
- ○Many patients' RPRs will decline to a low "serofast" level (1:2, 1:4) and remain there unless re-exposed.
- ○A 4-fold increase in titer in a previously declining or serofast RPR is suggestive of a new infection which will need to be retreated.

7. Gonococcal infections MUST be treated with dual therapy.

Due to concerns about increasing antimicrobial resistance, patients should receive dual therapy with ceftriaxone and azithromycin (**regardless** of chlamydia test results.) Patients who delay filling a prescription for their oral treatment more than 2 days after their injection will need to be retreated**. (Dual treatment given at the time of the clinic visit is optimal).** Doxycycline is **NOT** recommended for dual treatment of gonorrhea due to the already high prevalence of gonococcal resistance to this drug.

- ○**250 mg Ceftriaxone IM PLUS 1 gram of Azithromycin** orally given simultaneously is the recommended treatment.
- ○**240 mg gentamicin IM PLUS 2 grams of Azithromycin** orally given simultaneously is an alternative for patients reporting severe anaphylaxis or Stevens- Johnson syndrome after taking penicillin.
- ○**DO NOT GIVE Azithromycin alone** (GC resistance has been reported)
- ○Do a test of cure (at 14 days after treatment) for patients who receive non-recommended regimens.

8. All recent sexual contacts to GC (within 60 days) and early syphilis (within 90 days) should be tested AND treated.

Initial test results may be negative (while infections are incubating).

Expedited partner therapy (EPT) may be used for partners who are unable/unwilling to be screened in clinical setting. (EPT is **NOT** recommended for use with MSM).

9. Rescreen all patients with lab-confirmed GC or CT 3 months after treatment.

- ○Repeat infections are common, especially if partners have not been identified and treated.
- ○Expedited partner therapy (EPT) may be used for partners who are unable/unwilling to be screened in clinical setting. (**NOT** recommended for use with MSM).

10 Resources are available to assist you in diagnosing, treating, and preventing STIs.

- ○2015 CDC STD Treatment Guidelines
https://www.cdc.gov/std/tg2015/
- ○University of Washing STD Prevention Training Center
http://uwptc.org/
- ○Expedited Partner Therapy
http://www.oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/SexuallyTransmittedDisease/Pages/partnertherapy.aspx
- ○Syphilis Resources for Providers
http://www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/SEXUALLYTRANSMITTEDDISEASE/Pages/spr.aspx

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