



QUARTERLY REPORT

**1st Quarter
March 2012**

Marion County Health Department
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To report a communicable disease
(24 hours a day, 7 days a week)

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| Vital Statistics Quarter Ending: March 2012 | 1st Quarter 2012 2011 | | Year to Date 2012 2011 | |
|--|--------------------------|-------------|---------------------------|-------------|
| <u>BIRTHS</u> | | | | |
| TOTAL DELIVERIES | 1175 | 1196 | 1175 | 1196 |
| Delivery in Hospital | 1148 | 1181 | 1148 | 1181 |
| Teen Deliveries (10-17) | 37 | 44 | 37 | 44 |
| <u>DEATHS</u> | | | | |
| TOTAL | 649 | 674 | 649 | 674 |
| Medical Investigation | 64 | 62 | 64 | 62 |
| Homicide | 2 | 5 | 2 | 5 |
| Suicide | 14 | 10 | 14 | 10 |
| Accident – MVA | 6 | 6 | 6 | 6 |
| Accident – Other | 20 | 22 | 20 | 22 |
| Natural / Undetermined / Pending | 22 | 19 | 22 | 19 |
| Non-Medical Investigation (all natural) | 585 | 612 | 585 | 612 |
| Infant Deaths | 6 | 6 | 6 | 6 |
| Fetal Deaths | 2 | 2 | 2 | 2 |
| <u>COMMUNICABLE DISEASES</u> | | | | |
| E-Coli: 0157 | 0 | 0 | 0 | 0 |
| Hepatitis A | 0 | 0 | 0 | 0 |
| Acute Hepatitis B | 2 | 0 | 2 | 0 |
| Chronic Hepatitis B | 9 | 7 | 9 | 7 |
| Meningococcus | 0 | 1 | 0 | 1 |
| Pertussis | 7 | 10 | 7 | 10 |
| Tuberculosis | 0 | 2 | 0 | 2 |
| <u>SEXUALLY TRANSMITTED DISEASE</u> | | | | |
| PID (Pelvic inflammatory Disease) | 2 | 3 | 2 | 3 |
| Chlamydia | 368 | 410 | 368 | 410 |
| Gonorrhea | 24 | 18 | 24 | 18 |
| Syphilis | 2 | 2 | 2 | 2 |
| AIDS | 0 | 0 | 0 | 0 |
| HIV Positive | 2 | 3 | 2 | 3 |

GC and TB: Treatment Updates

Karen Landers MD MPH, Marion County Health Officer

ARG – The Bugs Outsmart the Drugs

April is sexually transmitted disease (STD) awareness month and gonorrhea (GC) happens to be the second most commonly reported communicable disease in the United States with an estimated incidence of over 600,000 cases annually. In Oregon, reported GC cases increased from 1078 in 2010 to 1490 in 2011. There is very bad news to report regarding gonorrhea treatment. Gonococcal infections are demonstrating emerging resistance to the remaining class of drugs, cephalosporins, which can still be used to treat them. Minimum inhibitory concentrations (MICs) of oral cephalosporins needed to effectively treat gonorrhea are gradually increasing at Gonococcal Isolate Surveillance Project (GISP) sites around the U.S. including Portland, Oregon, and treatment failures after using cephalosporins to treat GC have been reported internationally within the past two years. This recent epidemiologic pattern of cephalosporin susceptibility is similar to that previously observed when GC developed resistance to penicillin and tetracyclines in the 1980s and to fluoroquinolones in the last decade, and raises the horrible specter of ARG – antibiotic-resistant gonorrhea. In light of the past inability to prevent the development of resistance, the eventual emergence of cephalosporin-resistant GC appears likely. In an effort to delay the spread of cephalosporin-resistant strains and retain the ability to treat gonorrhea effectively, treatment recommendations for GC have changed.

Continued

Here's what you need to know:

DO NOT USE oral cephalosporins to treat suspected or confirmed GC.

Dual therapy with ceftriaxone and azithromycin is now recommended to treat gonococcal infections **REGARDLESS** of whether co-infection with chlamydia has been identified.

The recommended treatment regimen for GC is as follows:

Ceftriaxone 250 mg IM AND 1 gram of Azithromycin orally

2 grams of Azithromycin is recommended for use **ONLY** in persons with suspected or confirmed GC who are unable to take cephalosporins, **AND** should be followed by repeat testing in 3 weeks (test of cure).

Suspected cephalosporin treatment failures (persistence of symptoms with no re-exposure) should receive a culture for GC with susceptibility testing.

Report suspected or confirmed GC treatment failures to Marion County Health Department at **503. 588.5621** within one working day.

TB – Moving (slowly) Towards 0

Now, some good news! In 2011, 10,521 new active tuberculosis (TB) cases were reported in the U.S., resulting in the lowest TB rate since national reporting began in 1953. In 2011, Oregon TB cases numbered 74 (down from 87 in 2010); of these, 8 cases (11%) occurred in Marion County (up from 6 cases in 2010). Despite a steady decrease in U.S. TB cases since 1993, the 2011 national rate of 3.4 cases/100,000 population falls short of the 2010 TB elimination goal of <1 case/100,000. Approximately 4% of the U.S. population (11 million people) is infected with the TB bacterium but have no symptoms of active disease (latent TB infection). Maintaining progress towards TB elimination will require sustained TB control and prevention efforts going forward. With decreasing numbers of active TB cases, targeted screening of high risk persons and treatment of identified latent TB infection (LTBI) has become a cornerstone of the U.S. strategy for TB elimination. High risk persons include those more likely to be infected with *M. tuberculosis* (e.g., foreign-born, substance abusers, persons who reside in shelters or correctional institutions) as well as those who are more likely to progress to active disease if infected (e.g., recently infected with TB, those who are immunocompromised due to medical conditions or medications, other chronic illnesses such as diabetes, or renal disease, and children less than 5 years of age). Screening can be accomplished using either the tuberculin skin test (TST) or an interferon gamma release assay (IGRA) such as the QuantiFERON®-TB Gold In-Tube test.

But wait! There's more good news! A shorter treatment regimen for LTBI with fewer doses has recently become available. The Centers for Disease Control and Prevention (CDC) released guidelines in December 2011 for a 3 month LTBI treatment regimen that was shown in clinical trials to be as effective as nine months of isoniazid (INH) and significantly more likely to be completed.

Here's what you need to know:

The new regimen consists of 12 once-weekly doses of **rifapentine** (long-acting rifamycin) **AND isoniazid**.

Due to the intermittent dosing schedule, this regimen needs to be administered via directly observed therapy (DOT) e.g., under supervision of a health care worker.

This regimen is recommended for otherwise healthy people aged 12 and older with LTBI at high risk of progression to active disease including recent exposure to contagious TB, recently infected (TB test conversion within past 2 years) or chest x-ray suggestive of prior TB disease.

This regimen is also an option for patients living with HIV not currently taking antiretrovirals, and for use among populations that may not be as likely to complete 9 months of daily therapy with INH including persons who have resided in institutional settings such as corrections or homeless shelters.

The 12-dose LTBI regimen is **NOT** recommended for the following groups:

- Women who are pregnant or planning to become pregnant

- Children less than 2 years of age

- HIV-infected patients taking antiretrovirals

- Persons whose TB infection is presumed to be the result of exposure to infectious TB resistant to either INH or rifampin

For more information and dosing guidelines on this exciting new option for treating LTBI, please see:

3 Months of Rifapentine and INH for Latent TB Infection. NEJM 365; 23 pp. 2155-2166 Dec 8, 2011.

Recommendations for Use of an Isoniazid-Rifapentine Regimen with Direct Observation to Treat Latent *Mycobacterium tuberculosis* Infection. MMWR Vol. 60 No 48 December 9, 2011.