



Yakima Health District BULLETIN

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Resources

Sexually Transmitted Treatment Guidelines, CDC, 2002. <http://www.cdc.gov/STD/treatment/TOC2002TG.htm>

Washington State Department of Health STD Program <http://www.doh.wa.gov/cfh/STD/default.htm>

WNV Clinical Guidance, CDC http://www.cdc.gov/ncidod/dvbid/westnile/clinical_guidance.htm

WNV Prevention, CDC http://www.cdc.gov/ncidod/dvbid/westnile/prevention_info.htm

WNV Surveillance and Education, Washington State DOH <http://www.doh.wa.gov/ehp/ts/Zoo/WNV/WNV.html>

Washington State Cancer Registry <http://www3.doh.wa.gov/WSCR/html/WSCR2001rpt.shtm>

National Cancer Data <http://www.cdc.gov/cancer/natlancerdata.htm>

US Preventive Services Task Force <http://www.ahrq.gov/clinic/uspstfix.htm>

Gonorrhea Resurgence, Yakima County 2003-2004

Epidemiology

After reaching record lows in the latter part of the 1990s, reported cases of gonorrhea have been slowly and somewhat erratically increasing over the past several years (Figure 1).

From January 1-June 30, 2004, 90 cases were reported, predicting an annualized rate 60% higher than that observed in 2003. Although, as Figure 2 indicates, cases may have peaked in May, it is too soon to predict the true course of the outbreak. Women and men have accounted for roughly equal proportions of the cases, and two-thirds of the cases have been reported in persons less than 25 years of age. Consistent with historical observations of gonorrhea morbidity, female cases tend to be younger than male ones (Figure 3). All racial and ethnic groups have been represented, as have all cities in the county. Facilities reporting cases have been (in descending order) community clinics, family planning agencies, emergency rooms, and correctional/detention facilities. Co-infection with chlamydia was detected in 19 (21%). Half of all cases were treated on the same day the diagnosis was made, and 80% were treated within seven days. Only three cases were completely lost to follow-up. Investigation of cases to date indicates that the overwhelming majority are heterosexual. Most male cases report recent involvement with a new short term partner and many male cases have been over 35 years of age. Female cases have denied prostitution or exchanging sex for drugs or money, but there is still some suspicion that a small group of women are involved with drugs and prostitution.

Discussion

Although these gonorrhea rates still fall considerably below historical rates observed in prior years (Figure 2), they raise concern for several reasons. Bacterial sexually transmitted diseases are a proven causal risk factor for amplifying the transmission of human immu-

nodeficiency virus. Rising STD rates also are an indirect marker for sexual behaviors that are associated with HIV transmission (i.e., unprotected intercourse, frequent partner change). Gonorrhea can cause upper reproductive tract sequelae in women (e.g., pelvic inflammatory disease, tubal factor infertility, ectopic pregnancy) and serious infections in newborns of infected mothers (e.g., ophthalmia, sepsis). Finally, rising STD rates challenge the capacity of our primary health care system to provide timely, low-barrier care so that symptomatic persons and their recent sexual partners can be identified and treated promptly before further spread occurs. A particular challenge in this respect are the low-income male partners of infected women, for whom access to affordable reproductive health care is limited (most low-income women can qualify for state and federally funded reproductive health services through family planning agencies).

The gold standard for interrupting the chain of transmission of STDs has been to examine, perform diagnostic testing and appropriately treat all sex partners of persons diagnosed with a bacterial sexually transmitted disease. However, recent research has demonstrated that an intervention called "patient delivered partner therapy (PDPT)" can lead to comparable or even lower re-infection rates among cases of gonorrhea and chlamydia than have traditional partner notification efforts. In November 2003, the Washington State Medical Quality Assurance Commission formally recognized that "this is often the only reasonable way to access and treat the partner(s) and impact the personal and public health risks of continued, or additional, chlamydial and gonorrheal infections" and urged practitioners "to use all reasonable efforts to assure that appropriate information and advice is made

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Gonorrhea Resurgence con't.

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available to the absent treated third party or parties.”

This strategy is particularly relevant in Yakima County, because (aside from syphilis and HIV infection) YHD does not have dedicated resources for the routine investigation, clinical evaluation, and treatment of STD cases and their partners. Contraindications to use of PDPT include the presence of HIV infection or syphilis, men who have sex with men, and suspicion or knowledge that the patient is unable or unwilling to contact one or more partners. These situations warrant consultation with YHD for assistance in ensuring partner treatment. Under separate cover, YHD will soon be giving health care providers more comprehensive background information and recommendations on safe and effective use of PDPT.

Clinical Assessment, Treatment Recommendations and Case Reporting

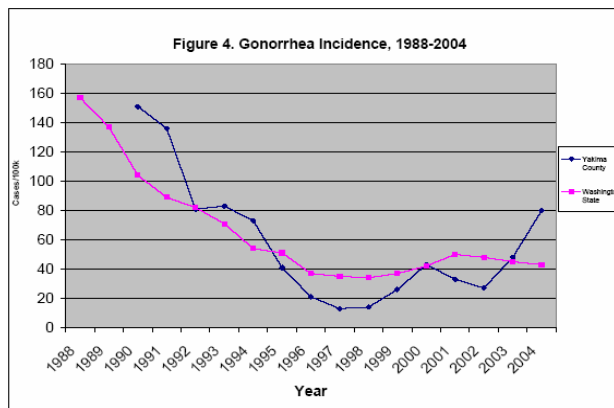
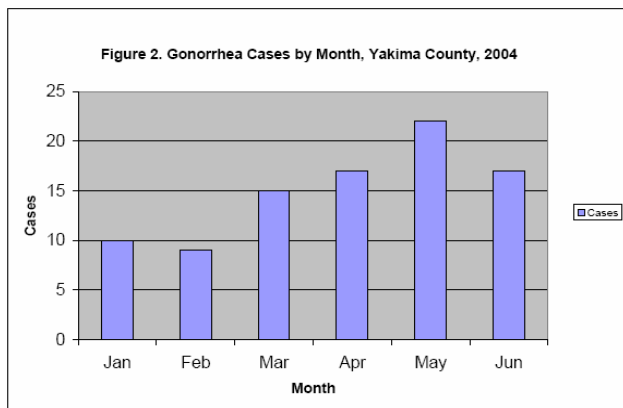
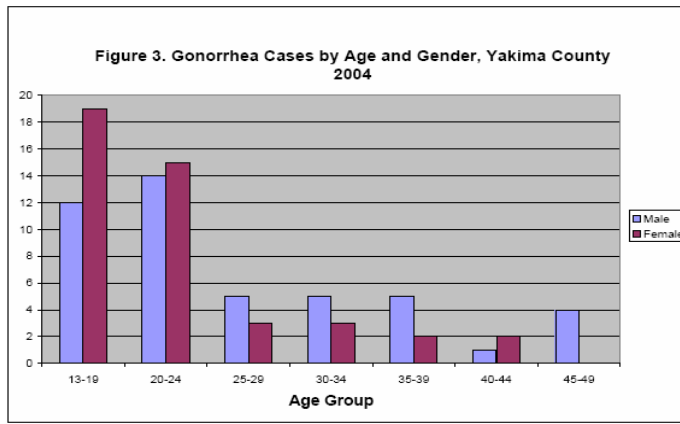
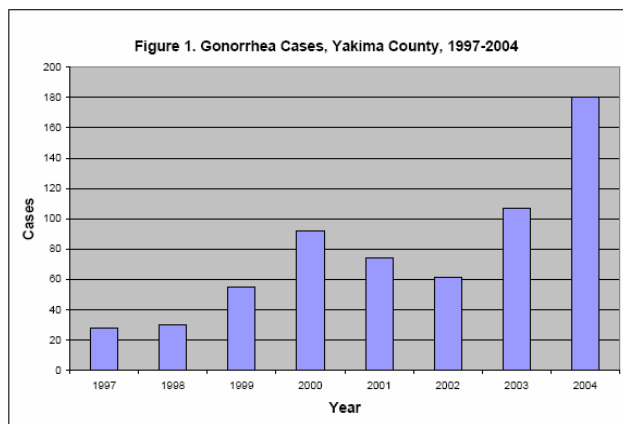
Include gonorrhea and chlamydia testing in the evaluation of persons of all ages who present with anogenital tract syndromes suggestive of STD (e.g., urethritis, cervicitis, salpingitis, epididymitis, proctitis) as well as in the routine screening of persons <25 years of age who report multiple

partners. In addition, chlamydia screening should be done at least annually among all sexually active women <25 years of age. All cases and contacts of gonorrhea should receive a single dose of ceftriaxone 125 mg IM or cefpodoxime 400 mg PO. Simultaneously, they should be given presumptive anti-chlamydial treatment (azithromycin 1 gm PO in a single dose or doxycycline 100 mg PO twice daily for seven days or levofloxacin 500 mg PO daily for seven days). Whenever possible, nucleic acid amplification-based laboratory testing and single dose directly observed therapy should be employed. Women with chlamydia should be tested for reinfection 3-4 months after treatment. Please report STD diagnoses (gonorrhea, chlamydia, syphilis, HIV, chancroid) to YHD at (509) 249-6541. To get more information or guidance on strategies for ensuring treatment of partners or other STD control issues, please contact Alex Popov at (509) 249-6531.

Additional Reading

Schillinger JA, et. al. Patient-delivered partner treatment with azithromycin to prevent repeated chlamydia trachomatis infection among women. *Sex Transm Dis* 2003;30(1):49-56.

Farley TA, et. al. Effectiveness of patient delivered partner medication for preventing recurrent Chlamydia trachomatis. *Sex Transm Inf* 1998;74:331-333.



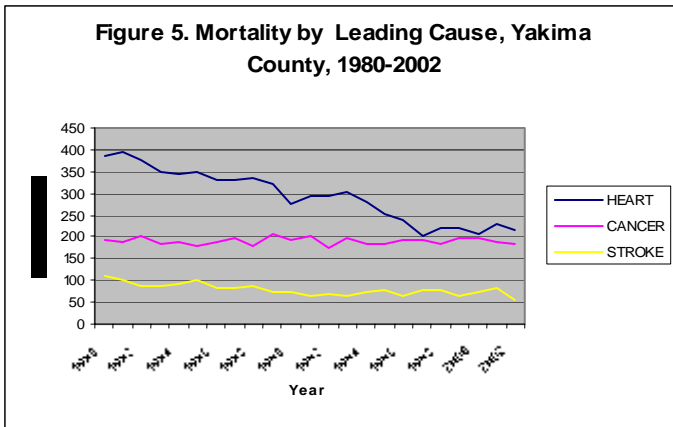
Cancer Surveillance

In 2002, malignant neoplasms were the second leading cause of death in Yakima County, accounting for 375 (21%) of 1755 deaths (Table 1). Cancer death rates are slightly lower in Yakima County than in Washington State as a whole. While heart and cerebrovascular disease death rates have been falling steadily for two decades (a nearly 50% decline), cancer death rates have not changed (Figure 5).

Leading Causes of Death for Residents, Yakima County, 2002

Rank	Cause	Deaths	Percent	Rate/100K	
				Yakima Co	Washington
1	Diseases of the Heart	465	26	207	195
2	Malignant Neoplasms	375	21	167	190
3	Cerebrovascular Diseases	125	7	56	66
4	Chronic Lower Respiratory Diseases	111	6	49	49
5	Unintentional Injury (Accident)	85	5	43	37
--	All Causes	1755	100	780	754

Cancers of the breast and prostate led all sites of incidence, whereas lung and colon were the leading sites for mortality (Table 2). Taken together, these four sites accounted for 55% of new cancer diagnoses. Cancers of the lung, colon, breast, pancreas, and lymphatic system accounted for 55% of cancer deaths. While mortality rates were remarkably similar by site between Yakima County and Washington State as a whole, incidence rates were lower in Yakima County for most of the leading sites. This difference



may reflect delayed or under-detection or underreporting more than they suggest true differences in incidence. If so, this reveals another indicator of hindered access to or utilization of primary and preventive health care services in Yakima County.

One noteworthy condition missing from this Table is invasive cancer of the cervix, which now accounts for only eight cases and two deaths per year. This represents a tremendous and ongoing victory in preventing cervical cancer through cytologic screening and appropriate management of precursor lesions, despite the fact that its causative agent, human papilloma virus infection, remains widely prevalent. Among the leading causes of cancer listed here, screening for early detection is definitively recommended by the United States Preventive Services

Task Force (USPSTF) only for the breast and colon. For other sites, there is either insufficient evidence to make a recommendation for or against routine screening or there is actually evidence to suggest that routine screening would be harmful. The USPSTF *does* strongly recommend that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. Finally, the USPSTF also concludes that the evidence is insufficient to recommend for or against the use of supplements of vitamins A, C, or E; multivitamins with folic acid; or antioxidant combinations for the prevention of cancer or cardiovascular disease.

Table 2. Average Annual Cancer Incidence and Mortality, Yakima County, 1999-2001

Rank	Site	Annual Cases	Incidence/100K***		Annual Deaths	Deaths/100K***	
			Yakima Co	Washington		Yakima Co	Washington
1	Breast*	156	148	182	23	21	24
2	Prostate**	139	157	181	4	30	29
3	Lung	128	64	72	114	57	57
4	Colorectal	103	51	54	42	20	19
5	Melanoma	55	28	37	7	3	3
Total (of top 10 causes)		953	475	549	393	194	196

* Rate calculations include only females in denominator
 ** Rate calculations include only males in denominator
 *** Age-adjusted to 2000 U.S. Census Population

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ext 541 for CD reporting and information

After hours Public Health Emergencies:

509-575-4040 #1 (answering service)

Toll Free: 800-535-5016

Fax: 509-575-7894

<http://www.co.yakima.wa.us/health/default.html>

Dennis Klukan, Administrator

Christopher Spitters, M.D., Health Officer



Prevention is Our Business

West Nile Virus (WNV) Update

Surveillance and Reporting

Although no human or animal cases have yet been identified in Washington State during this or last year, WNV activity has been found as close as Idaho (1 animal or mosquito case) and California (28 human cases) in 2004. Furthermore, WNV often first strikes a naïve environment in the late summer or early fall. Therefore, an index of clinical suspicion should be maintained for patients presenting with compatible febrile or neurologic syndromes. Please report all cases meeting the following criteria to YHD at (509) 249-6541:

WNV neuroinvasive disease:

- Fever in the absence of a more likely clinical explanation in a patient with at least one of the following:
 - Acute change in mental status
 - Other acute central or peripheral neurological dysfunction
 - Cerebrospinal fluid pleocytosis with an illness compatible with meningitis
- Testing will be available through the Washington State Public Health Laboratory for such patients

WNV non-neuroinvasive disease with commercial laboratory evidence of WNV infection:

- Documented fever ($\geq 38.0^{\circ}\text{C}$) in the absence of a more likely clinical explanation
- Refer initial testing to a commercial laboratory. Confirmatory testing of reactive specimens from a commercial laboratory will be available at PHL on a limited basis

Laboratory evidence of WNV infection in any pregnant woman; neonate or breastfeeding infant; blood product, tissue, or organ donor or recipient; or person with occupational exposure to WNV.

Laboratory Testing

IgM antibody capture enzyme immunoassay (EIA) of serum or CSF is the most sensitive test for WNV infection in immunocompetent patients. More than 90% of those infected will have detectable serum IgM by eight days after onset, and CSF antibody may be present even earlier. For patients with non-reactive or indeterminate serum specimens obtained *before* the eighth day of illness, a repeat specimen may be requested. Polymerase chain reaction (PCR) assay may be performed on CSF or blood for evaluation of patients with immune dysfunction, but PCR is not recommended by CDC for routine diagnosis of WNV disease.