Disease Control Program

California Gonorrhea Surveillance System

Effective January 1, 2007, the Santa Barbara County Public Health Department’s Disease Control Program has begun participation in the California Gonorrhea Surveillance System (CGSS). Gonorrhea (GC) is the second most commonly reported disease in California (CA) with nearly 35,000 cases reported in 2005. Following many years of decline, CA has recently seen increases in GC cases in all demographic groups. Reasons for the state-wide increases are not fully understood.

Locally, we have actually experienced a decline in the total number of cases reported for 2006 (85) compared to 2005 (115). This represents a 26.1% decrease. Hopefully, the trend will continue with effective and timely treatment of patient and their contacts.

It has been difficult to design effective targeted interventions to prevent the spread of GC in CA due to the lack of adequate data. By obtaining more detailed epidemiologic and risk data on GC cases in CA through ongoing case follow-up, the CGSS will significantly contribute to our understanding of GC epidemiology. Contact the Disease Control Office at (805) 681-5280 with any questions on STI testing, reporting or treatment.

New Gonorrhea Treatment Legislation

As of January 1, 2007, AB 2280 (Leno) amended prior law to allow physicians, nurse practitioners, physician assistants and certified nurse-midwives who diagnose chlamydia, gonorrhea (GC), or other sexually transmitted infections (STIs) to prescribe, dispense, furnish or otherwise provide prescription antibiotic drugs to that patient’s sexual partner or partners without examination of that patient’s partner or partners. The law now provides that a licensee acting in accordance with provisions of the law with regard to a prescription for antibiotic therapy has not committed unprofessional conduct. This law provides an important means to combat a serious public health problem and prevent adverse reproductive health outcomes. Although the legislation permits patient-delivered partner treatment (PDPT) regardless of the patient’s gender or sexual orientation, the use of PDPT in certain populations (e.g., heterosexual males and men who have sex with men) may increase the risk of under-treating a complicated infection or missing a concurrent HIV infection. PDPT is not intended as the first and optimal choice of treatment for partners of individuals diagnosed with GC. Rather, every attempt should be made to arrange for a clinical evaluation at which time the partner(s) can receive testing, counseling, and treatment for sexually transmitted diseases. PDPT programs should include educational materials that accompany medications and counseling recommending abstinence until seven days after treatment and partner treatment. Re-testing of all patients diagnosed with chlamydia or GC should be conducted three months after treatment. Recommended treatment regimens for STIs are available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm.
Healthier communities through leadership, partnership, and science.

**Epidemiology Program**

**Norovirus Activity**

We are in the midst of a heavy norovirus season locally, statewide and nationally with activity at 2-3 times the usual levels! From October 1 through December 31, 2006, 237 non-foodborne outbreaks of acute gastroenteritis, confirmed or consistent with norovirus, have been reported to CDHS to date. From the same period in 2005 and 2004, there were 28 and 62 non-foodborne acute gastroenteritis outbreaks reported, respectively. Over half of the outbreaks occurred in skilled nursing facilities and the majority of the remainder in a variety of senior care or residential settings, which is similar to past years. Here in Santa Barbara County, we are experiencing the same with Disease Control staff having been involved in multiple large outbreak investigations (in excess of 100 ill persons in some instances) at local long-term care facilities and schools.

The Control of Viral Gastroenteritis Outbreaks in Long Term Care Facilities can be found by visiting: www.dhs.ca.gov/ps/dcdc

**HIV/AIDS Program**

**HIV Name-based Reporting Emergency Regulations**

On January 8, 2007, the California Department of Health Services issued the HIV name-based reporting regulations. Emergency regulations go into effect as soon as issued. However, a 45 day public comment period was in effect until late February 2007. The Emergency Regulations are essentially the same as those policies and procedures put into place by the Santa Barbara County Public Health Department. The main departure is that HIV names reporting must be either submitted by laboratories and physicians either through secure, traceable mail sources (e.g. FedEx, UPS, DHL, etc.) or through a secure courier. The Santa Barbara County Public Health Department has previously issued alerts and information on HIV names-based reporting. These materials may be found on the County’s website at: http://www.sbcphd.org under the HIV/AIDS program webpage. For questions about reporting requirements, please contact the HIV/AIDS Office at (805) 681-5421.

**CDC Recommendation for HIV Testing in Routine Healthcare Settings**

In September 2006, the Centers for Disease Control (CDC) issued revised recommendations for HIV testing for those 13-64 years of age and for all pregnant women seen in healthcare settings. These recommendations replaced the previous 1993 recommendations for HIV testing in inpatient and outpatient acute-care hospital settings.

In California, specific oral or written consent is required for HIV testing, and providers are cautioned about the CDC’s recommendation concerning incorporating HIV testing consent into general consents. This also prohibits “opt-out” screening without first receiving the client’s consent. “Opt-out” screening has been working well for HIV testing for pregnant women, but signed requests for “opt-out” and signed indications of the HIV test being offered are part of the current requirements.

The CDC has also issued Questions and Answers for Professional Partners: Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Healthcare Settings. These may be found at the following website: http://www.cdc.gov/hiv/topics/testing/resources/qa/qa_professional.htm

Copies of the guidelines may be found at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

**Grand Rounds and Trainings**

The Grand Rounds and Calendar of Training at the Southern California Pacific AIDS Education and Training Center at the University of Southern California, Keck School of Medicine, the Charles R. Drew University of Medicine and Science, the David Geffen School of Medicine at UCLA, and at the Universities of California at Irvine and San Diego can be found by searching for PAETC using any web search engine.
Immunization Program

General Recommendations on Immunization - December 1, 2006

The latest recommendations from the Advisory Committee on Immunization Practices (ACIP) were published in the MMWR on December 1, 2006. The report is intended to serve as a general reference on vaccines and immunization. There were several changes, the principal ones being:

- Expanded discussion of vaccination spacing and timing
- Increased emphasis on the importance of injection technique/age/body mass in determining the appropriate needle length to be used
- Expanded discussion of storage and handling of vaccines
- Expanded discussion of altered immunocompetence, including recommendations on use of live-attenuated vaccines with therapeutic monoclonal antibodies
- Minor changes to the recommendations regarding vaccination during pregnancy and vaccination of internationally adopted children

A full copy of the report can be found at www.cdc.gov/mmwr/PDF/rr/rr5515.pdf.

Recommended Immunization Schedules for Persons Aged 0-18 years
United States, 2007 (the MMWR Quick Guide)

The Recommended Immunization Schedules for Persons Aged 0-18 years, United States, 2007 (the MMWR Quick Guide) was printed January 5, 2007. The changes to the previous childhood and adolescent immunization schedule, published January 2006, include:

- The new rotavirus vaccine recommendations
- Influenza vaccine now recommended for all children aged 6-59 months
- Varicella vaccine recommendations are updated, with recommendations that the first dose be administered at age 12-15 months and a newly recommended second dose be administered at age 4-6 years.
- The new human papillomavirus vaccine (HPV) recommendations
- A major change to the format of the schedule is the division of the recommendations into two schedules: one schedule for persons aged 0-6 years and another for persons aged 7-18 years.

The MMWR Quick Guide can be found at www.cdc.gov/mmwr/pdf/wk/mm5551-immunization.pdf

In the News...

Falsey AR et al. Impact of rapid diagnosis on management of adults hospitalized with influenza. Arch Intern Med 2007 Jan 22; 167. The rapid antigen-positive patients were less likely to receive antibiotics (86% vs. 99%; P<0.002) and more likely to receive an antiviral agent (73% vs. 8%; P<0.001) than were the other patients.

Widmer AF et al. Introducing alcohol-based hand rub for hand hygiene: The critical need for training. Infect Control Hosp Epidemiol 2007 Jan; 28:50-4. At baseline, fewer than half of the HCWs used the recommended technique for hand-rub application.

Sorvillo FJ et al. Deaths from cysticercosis, United States. Emerg Infect Dis 2007 Feb; 13:230-5. The researchers identified 221 cysticercosis deaths in the U.S. during the 13-year period (mean age at death 40.5 years [range, 2–88]; 62% male; 85% Latino). Among those who died, 85% were foreign-born, and 62% were immigrants from Mexico.


Santa Barbara County Medical Reserve Corps (MRC) Applications

Medical and public health professionals responding to natural disasters and emergencies

Meetings are held at the Santa Barbara Public Health Department

Call John Eaglesham for application details and meeting dates: 681-5394 or email JEaglesham@sbcphd.org or visit www.sbcphd.org/ems/mrc/form.html
TB ANYWHERE IS TB EVERYWHERE is the theme for 2007’s World TB Day on March 24th, offering a message of urgency and shared responsibility. Through unified action on all levels, we can work towards a world finally free of tuberculosis.

The Santa Barbara County Public Health Department’s Disease Control Program wishes to thank the local healthcare community for ongoing surveillance and reporting which contributes greatly to our efforts to Stop TB. Our ability to Stop TB can only be accomplished through a shared partnership whereby we can promptly identify and treat active TB cases and their contacts. The Disease Control Program staff can provide your office with TB educational materials. For more information on Stop TB visit: www.stoptb.org

Please contact us at (805) 681-5280 for TB or other communicable disease information.
CALIFORNIA STD TREATMENT GUIDELINES FOR ADULTS & ADOLESCENTS 2007

These guidelines for the treatment of patients with STDs reflect the 2006 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens and are not intended to substitute for use of the full 2006 STD treatment guidelines document. Call the local health department to report STD infections; to request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients. The California STD/HIV Prevention Training Center is an additional resource for training and consultation in the area of STD clinical management and prevention (510-625-6600) or www.stdhivtraining.org.

1. Annual screening for women age 25 years or younger. Nucleic acid amplification tests (NAATs) are recommended. All patients should be tested 3 months after treatment for chlamydia or gonorrhea infections.

2. Contraindicated for pregnant and nursing women.

3. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy.


5. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.

6. Spectinomycin has not been manufactured since January 2006, and future availability is uncertain.

7. Cefixime tablets have not been available in the U.S. since November 2002. An oral suspension formulation is available.

8. Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management, and because these infections are reportable by primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens and are not intended to substitute for use of the full 2006 STD treatment guidelines document. Call the local health department to report STD infections; to request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients. The California STD/HIV Prevention Training Center is an additional resource for training and consultation in the area of STD clinical management and prevention (510-625-6600) or www.stdhivtraining.org.

9. Evaluation for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole.

10. Safety in pregnancy has not been established; pregnancy category C.

11. Fluoroquinolones may be used for PID in California if the risk of gonorrhea is low, a NAAT test for gonorrhea is performed, and follow-up of the patient is considered likely.

12. If gonorrhea is documented, a change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.

13. If gonorrhea is documented, a change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.


15. Safety in pregnancy has not been established; pregnancy category C.

16. Might weaken latex condoms and diaphragms because oil-based.

**DISEASE**

**RECOMMENDED REGIMENS**

**DOSE/ROUTE**

**ALTERNATIVE REGIMENS:** To be used if medical contraindication to recommended regimen

**CHLAMYDIA**

Uncomplicated Genital/Rectal/Pharyngeal Infections 1

- Azithromycin or Doxycycline 2
- A chlamydia recommended regimen listed above if not ruled out by NAAT

Pregnant Women

- Azithromycin or Amoxicillin
- A chlamydia recommended regimen listed above if not ruled out by NAAT

**GONORRHEA**

Ceftriaxone is the preferred treatment for adult and adolescent patients with uncomplicated gonorrhea infections. Fluoroquinolones are no longer recommended for treatment of gonococcal infections in California because of high levels of resistance to this class of drugs. Routine use of azithromycin to treat gonorrhea is not recommended because of mounting concern about emerging resistance. Complete guidelines for the treatment of gonorrhea in California are available at www.std.ca.gov.

Uncomplicated Genital/Rectal/Pharyngeal Infections 1

- Ceftriaxone or Doxycycline
- A chlamydia recommended regimen listed above if not ruled out by NAAT

Pregnant Women

- Ceftriaxone or Doxycycline
- A chlamydia recommended regimen listed above if not ruled out by NAAT

**PELVIC INFLAMMATORY DISEASE**

**CERVICITIS**

- Azithromycin or Doxycycline
- A chlamydia recommended regimen if BV is present

**NONGONOCOCCAL URETHRITIS**

- Azithromycin or Doxycycline
- A chlamydia recommended regimen if BV is present

**EPIDIDYMISIS**

- Likely due to Gonorrhea or Chlamydia
- Doxycycline
- A chlamydia recommended regimen if BV is present

**TRICHOMONIASIS**

Non-pregnant women

- Metronidazole or Tinidazole

Pregnant Women

- Metronidazole

**BACTERIAL VAGINOSIS**

Adults/Adolescents

- Metronidazole or Metronidazole gel or Clindamycin cream

Pregnant Women

- Metronidazole or Metronidazole gel or Clindamycin
<table>
<thead>
<tr>
<th>DISEASE</th>
<th>RECOMMENDED REGIMENS</th>
<th>DOSE/ROUTE</th>
<th>ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANCROID</td>
<td>- Azithromycin or - Ceftriaxone or - Ciprofloxacin or - Erythromycin base</td>
<td>1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d</td>
<td>• Erythromycin base 500 mg po qid x 21 d or • Azithromycin 1 g po q week x 3 weeks</td>
</tr>
<tr>
<td>LYMPHOGRAVULOMA VENEREUM</td>
<td>- Doxycycline</td>
<td>100 mg po bid x 21 d</td>
<td>- Alternates should only be used for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.</td>
</tr>
</tbody>
</table>

**ANOGENITAL WARTS**

<table>
<thead>
<tr>
<th>External Genital Perianal Warts</th>
<th>Patient Applied</th>
<th>Provider Administered</th>
<th>Topically qhs 3 x wk up to 16 wks</th>
<th>Topically bid x 3 d followed by 4 d no tx for up to 4 cycles</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Imiquimod 5% cream or - Podofilox 0.5% solution or gel</td>
<td>- Cryotherapy or - Podophyllin resin 10%-25% in tincture of benzoin or - Trichloroacetic acid (TCA) 90%-90% or - Bichloroacetic acid (BCA) 90%-90% or - Surgical removal</td>
<td>Apply once q 1-2 wks</td>
<td>Apply once q 1-2 wks</td>
<td>Apply once q 1-2 wks</td>
</tr>
</tbody>
</table>

**Mucosal Genital Warts**

- Cryotherapy or - TCA or BCA 90%-90% or - Podophyllin resin 10%-25% in tincture of benzoin or - Surgical removal

Vaginal, urethral meatus, and anal Vaginal and anal Urethral meatus only Anal warts only

**ANOGENITAL HERPES**

<table>
<thead>
<tr>
<th>First Clinical Episode of Herpes</th>
<th>- Acyclovir or - Famciclovir or - Valacyclovir</th>
<th>- Acyclovir or - Famciclovir or - Valacyclovir</th>
<th>400 mg po tid x 7-10 d</th>
<th>200 mg po 5/day x 7-10 d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Infection</td>
<td></td>
<td></td>
<td>- Valacyclovir</td>
<td>1 g po bid x 7-10 d</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Suppressive Therapy</th>
<th>- Acyclovir or - Famciclovir or - Valacyclovir</th>
<th>- Acyclovir or - Famciclovir or - Valacyclovir</th>
<th>400 mg po bid</th>
<th>250 mg po bid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Episodes</td>
<td>- Acyclovir</td>
<td>- Valacyclovir</td>
<td>1 g po qd</td>
<td></td>
</tr>
</tbody>
</table>

**HIV Co-Infected**

<table>
<thead>
<tr>
<th>suppressive therapy</th>
<th>- Acyclovir or - Famciclovir or - Valacyclovir</th>
<th>- Acyclovir or - Famciclovir or - Valacyclovir</th>
<th>400-800 mg po bid or tid</th>
<th>500 mg po bid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Episodes</td>
<td>- Acyclovir or - Famciclovir or - Valacyclovir</td>
<td>- Acyclovir</td>
<td>1 g po bid x 5-10 d</td>
<td></td>
</tr>
</tbody>
</table>

**SYPHILIS**

<table>
<thead>
<tr>
<th>Primary, Secondary, and Early Latent</th>
<th>- Benzathine penicillin G</th>
<th>2.4 million units IM</th>
<th>1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late Latent and Late of Unknown duration</td>
<td>- Benzathine penicillin G</td>
<td>7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals</td>
<td>• Tetracycline 250 mg po qid x 3 weeks or • Ceftriaxone 1 g IM or IV qd x 6-10 d</td>
</tr>
<tr>
<td>Neurosyphilis</td>
<td>- Aqueous crystalline penicillin G</td>
<td>18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d</td>
<td>• Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus • Ceftriaxone 2 g IM or IV qd x 10-14 d</td>
</tr>
</tbody>
</table>

**Pregnant Women**

<table>
<thead>
<tr>
<th>Primary, Secondary, and Early Latent</th>
<th>- Benzathine penicillin G</th>
<th>2.4 million units IM</th>
<th>• None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late Latent and Late of Unknown duration</td>
<td>- Benzathine penicillin G</td>
<td>7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals</td>
<td>• None</td>
</tr>
<tr>
<td>Neurosyphilis</td>
<td>- Aqueous crystalline penicillin G</td>
<td>18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d</td>
<td>• Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus • Ceftriaxone 2 g IM or IV qd x 10-14 d</td>
</tr>
</tbody>
</table>

**HIV Co-Infected**

<table>
<thead>
<tr>
<th>Primary, Secondary, and Early Latent</th>
<th>- Benzathine penicillin G</th>
<th>2.4 million units IM</th>
<th>• Tetracycline 750 mg po bid x 3 weeks or • Ceftriaxone 1 g IM or IV qd x 6-10 d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late Latent and Late of Unknown duration with normal CSF Exam</td>
<td>- Benzathine penicillin G</td>
<td>7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals</td>
<td>• Tetracycline 180 mg po bid x 28 d</td>
</tr>
<tr>
<td>Neurosyphilis</td>
<td>- Aqueous crystalline penicillin G</td>
<td>18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d</td>
<td>• Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus • Ceftriaxone 2 g IM or IV qd x 10-14 d</td>
</tr>
</tbody>
</table>

17. Contraindicated in pregnancy.
18. Cervical warts should be managed by a specialist.
19. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
20. The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission.
21. If HIV lesions persist or recur while receiving antiviral treatment, antiviral resistance should be suspected. A viral isolate should be obtained for sensitivity testing, and consultation with an infectious disease expert is recommended.
22. Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name) which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.
23. Alternates should only be used for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.
24. Some specialists recommend 2.4 million units of benzathine penicillin G per week for up to 3 weeks after completion of neurosyphilis treatment.
25. Patients allergic to penicillin should be treated with penicillin after desensitization.

Developed by the California STD/HIV Prevention Training Center
Revised March 2007