QUARTERLY REPORT

1st Quarter
March 2010

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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 2010	1st Quarter 2010	1st Quarter 2009	Year to Date 2010	Year to Date 2009
BIRTHS TOTAL DELIVERIES	1273	1261	1273	1261
Delivery in Hospital	1259	1242	1259	1242
Teen Deliveries (10-17)	56	49	56	49
DEATHS TOTAL	640	692	640	692
Medical Investigation	68	68	68	68
Homicide	1	4	1	4
Suicide	13	8	13	8
Accident – MVA	3	7	3	7
Accident – Other	19	21	19	21
Natural / Undetermined / Pending	30	28	30	28
Non-Medical Investigation (all natural)	572	624	572	624
Infant Deaths	3	3	3	3
Fetal Deaths	2	5	2	5
COMMUNICABLE DISEASES E-Coli: 0157	0	0	0	0
Hepatitis A	0	1	0	1
Acute Hepatitis B	2	0	2	0
Chronic Hepatitis B	12	8	12	8
Meningococcus	0	0	0	0
Pertussis	3	5	3	5
Tuberculosis	1	1	1	1
SEXUALLY TRANSMITTED DISEASE PID (Pelvic inflammatory Disease)	3	5	3	5
Chlamydia	412	376	412	376
Gonorrhea	34	44	34	44
Syphilis	2	2	2	2
AIDS	3	1	3	1
HIV Positive	2	1	2	1

Sexually Transmitted Infections in Marion County and Oregon: Updates on Treatment and Prevention

Karen Landers MD MPH, Marion County Health Officer

April is Sexually Transmitted Disease Awareness Month, when the continued impact of sexually transmitted infections (STIs) on the health of the community is acknowledged, and strategies for reducing and preventing the spread of STIs are re-emphasized. Reported cases of *Chlamydia trachomatis* (CT) continue to trend upwards in Marion County and Oregon. In 2009, Marion County ranked second in the State in reported CT cases. Although total numbers are low, a recent increase in the number of early syphilis cases is also worrisome; most of the cases are being reported in men who have sex with men (MSM). (See graph) The development of antimicrobial resistance in *Neisseria gonorrhoeae* (GC) is a growing public health concern. At this time, only one remaining class of antibiotics (cephalosporins) is recommended for the treatment of gonococcal infections. Historically, gonorrhea has progressively developed resistance to all the antibiotic drugs used to treat it, including penicillin, tetracycline, spectinomycin,and ciprofloxacin. Sensitivity to cephalosporins in GC isolates is being closely monitored in selected sites and laboratories across the country.

Testing and Treatment = Prevention

Because many people with a sexually transmitted infection may be unaware of it or may not manifest symptoms, taking a careful sexual history and screening people with risks for STIs is critical to identifying infections and treating early to reduce transmission to others. Testing and treating identified sexual contacts exposed to a patient diagnosed with an STI is key to reducing the ongoing spread as well as reducing the risk of re-infection in the index patient.

Continued

Key screening and treatment recommendations include:

Adolescents:	Screen for sexual activity. Vaccinate for HPV. (May also be used in males) Screen for HIV, GC, CT, and other STIs if sexually active.
Pregnancy:	Routinely screen for HIV, syphilis, Hepatitis B surface antigen, CT at first prenatal visit; include GC and consider repeat screening in the third trimester for women with ongoing risks.
MSM:	At least annually for HIV, syphilis, GC with more frequent screening (3-6 months) for sexually active MSM with multiple or anonymous partners, and/or illicit drug use.

- All patients diagnosed with GC should also receive treatment for CT as co-infection is common.
- Patients with GC should be treated with a cephalosporin. **DO NOT USE** fluoroquinolones. Ceftriaxone injection is preferred as it also rovides coverage for pharyngeal GC, but cefixime or cefpodoxime may also be used. Penicillin-allergic patients may be treated with azithromycin.
- Test and treat the sexual contacts of patients with positive tests for GC, CT, and syphilis.

Expedited Partner Therapy (EPT)

Effective January 1, 2010, EPT was authorized by the Oregon Legislature (HB 3022). EPT is designed to assist with treatment of sexual partners who have been exposed to GC or CT, and in whom it has been determined that a medical evaluation is unlikely or unable to be completed. EPT has been shown to reduce re-infection by approximately 25%; in Oregon that translates to an estimated 200 fewer cases of chlamydia and 11 fewer cases of GC per year. Oregon Board of Pharmacy rule changes took effect on 2/5/2010 which permit pharmacists to legally fill a prescription intended to treat partners exposed to patients diagnosed with CT or GC.
What you need to know:

- The patient's diagnosis must be *Chlamydia trachomatis* or *Neisseria gonorrhea*.
- EPT may consist of either a prescription for antibiotics or provision of medications.
- Informational materials must accompany the prescription or medication and include clear instructions, warnings, and referral recommendations.
- The number of partners that can be prescribed medication for EPT should be limited to known sexual contacts to the patient in the previous 60 days or the most recent sexual partner if none were identified in the previous 60 days.
- A unique prescription must be written for each partner. EPT prescriptions not containing the name of the partner must be annotated with "for EPT" or "EPT prescription".
- Retesting patients for GC and CT 3 months after treatment is strongly recommended. Re-infection occurs most commonly in the first months after diagnosis and treatment.

For more on EPT and model informational materials in English and Spanish, visit: www.oregon.gov/DHS/ph/STD/partnertherapy.shtml.