



Communicable Disease and Epidemiology News

Published continuously since 1961
Edited by Sherry Lipsky, P.A.-C, M.P.H.



Seattle-King County
Department of Public Health
Epidemiology
First Interstate Building
999 Third Avenue, Ste. 900
Seattle, WA 98104 - 4039

BULK RATE
u.s. Postage
PAID
Seattle, WA
Permit No. 7246

Return Service Requested

TIME VALUE

IN THE MARCH 1998 ISSUE:

VOL 38, NO. 3

- **HIV Outbreak: The Seattle-Vancouver Connection**
- **HIV/AIDS Among American Indian & Alaskan Natives**
- **Upcoming Course on Vaccine-Preventable Diseases**

HIV Outbreak

In early March, 1998, the Washington State Department of Health convened a meeting to discuss the public health policy implications in Washington state of the HIV outbreak in injection drug users that began in Vancouver, B.C. in 1994¹ and to learn from the experience of researchers and public health officials in Vancouver. Public health officers and staff from every Washington state AIDSNET region, as well as representatives of the Centers for Disease Control and Prevention (CDC), attended the meeting. The details of the Vancouver outbreak and the current public health strategies there, and the results of studies describing incidence and prevalence of HIV and other blood-borne viruses in Vancouver and Washington state were presented.

At the height of the outbreak, HIV seroincidence in Vancouver drug injectors reached 18% per year; it has since fallen to 2-4% per year. The outbreak investigation suggested that an increase in cocaine use occurred during the same period, leading to the hypothesis that the shorter duration of drug effect for cocaine versus heroin led to an increased rate of injection that contributed to the rise in HIV incidence. Other factors believed to have fueled the outbreak were underlying social and health problems in the Downtown Eastside neighborhood, where there is a concentration of drug use. The Vancouver experience has sparked international interest because of concern that the HIV incidence might follow the high rates in East Coast cities, where resulting prevalence of HIV infection in IDUs is usually above 50%.

Dr. Stephanie Strathdee, of the Vancouver study of drug injectors, reported on the status of HIV incidence in Vancouver, and discussed her findings that four percent of Vancouver study participants had some recent

connection to Washington state, having recently relocated from or traveled to Seattle. Kris Nyrop, Director of Street Outreach Services (a social service agency in Seattle) and an ethnographer, reported on his comparison between the drug use and drug market scenes in Seattle and Vancouver. His data indicate that the price, availability, and quality of heroin and cocaine in Seattle has not changed much over the past several years, while in Vancouver the price of cocaine and heroin had dropped with no loss of drug purity. Dr. James McGough of the Seattle King County Department of Public Health (SKCDPH) described a cohort of 3000 Seattle area injection drug users; only a small proportion of study participants had any connection to Vancouver, but notable exceptions included female injectors involved in the sex industry. There is no indication that use of cocaine is on the rise in Seattle area drug users. Dr. Hanne Thiede reported that, for injectors remaining in methadone drug treatment in the Seattle area, there was a marked reduction in injection risk behavior compared to those who dropped out. Dr. Holly Hagan reported on an analysis of the association between syringe exchange and risk of infection with hepatitis B or C viruses in Seattle; the exchange appears to have little effect on transmission of these agents, while HIV incidence rates have remained below 0.5% per year.

During the afternoon discussion, participants identified topics where more information or resources are needed to make informed public health policy decisions; these included local data on drug use and injection risk behavior from other parts of the state. At the present time, the research conducted in Seattle is the only source of data, and the counties that lie between Seattle and the Canadian border are particularly interested in migration

and travel by drug injectors between the regions. Also mentioned were the need for more sharing of information across the state, more resources for drug treatment, and for needle exchange programs. A smaller work group will summarize the results from this meeting to be used to guide planning for strengthening the monitoring of HIV and targeted prevention to high-risk populations.

¹ Strathdee SA, Patrick DM, Currie SL, et. Al. Needle exchange is not enough: Lessons from the Vancouver injecting drug use study. AIDS 1997;11:F59-65.

HIV/AIDS in AI/AN

In a recent MMWR article (Vol 47, No 8), the CDC reported on trends in AIDS incidence and characteristics of American Indians and Alaskan Natives (AI/AN) with HIV and AIDS. Of particular interest is the finding that more than half (53%) of AI/AN with AIDS reported through December 1997 resided in five states at the time of diagnosis, including Washington state (7%), and the Seattle-Bellevue-Everett area was noted as being among the five metropolitan statistical areas with the highest percentages of AI/AN with AIDS (4%). However, compared with all persons with AIDS, a lower proportion of AI/AN resided in large metropolitan areas, and a higher proportion resided in smaller rural areas.

The most frequently reported mode of HIV exposure in AI/AN with AIDS was men who have sex with men (MSM), similar to all persons with AIDS in the U.S. (49% and 48%, respectively; among men the proportions were 58% and 57%, respectively). However, a larger percentage of AIDS cases in AI/AN were associated with MSM who also were injection-drug users (IDUs) compared to all AIDS cases (14% vs. 6%; among men 16% vs 8%). This finding is also highlighted in the most recent HIV/AIDS Quarterly Epidemiology Report (4th Quarter, 1997) published by the SKCDPH and Washington State Department of Health. A summary of an analysis

from the Seattle Adult Spectrum of HIV-related Diseases (ASD) study is presented; data for a sample of HIV-infected individuals from nine outpatient clinics and medical offices in King County between January 1990 and August 1997 were abstracted from medical records. Seattle ASD is part of a multicenter CDC study tracking trends in the presentation, course, and treatment of HIV infection. The local study found that male AI/AN were significantly more likely than non-AI/AN males to be MSM who are also IDUs (41% vs. 19%), a much greater difference than described in the CDC study. The SKC study also revealed a smaller proportion of AI/AN men in the MSM exposure category compared to the U.S. AI/AN population (43% vs. 59%).

Other significant characteristics in the SKC ASD cohort of AI/AN were younger age compared to the non-AI/AN group (median 31 vs 33 years), more likely to be female (31% vs 11%), more likely to have category B symptoms rather than clinical AIDS, more likely to be diagnosed with a STD (particularly women), and more likely to have a reactive PPD skin test. Finally, AI/AN were more likely to be alive at the most recent follow-up, which is consistent with the smaller proportion of AIDS compared to the non-AI/AN in this study. Women in both groups were highly likely to be pregnant; this combined with a high rate of STDs in HIV-infected AI/AN women suggests that heterosexual sex is an important transmission mode in this population.

While AI/AN comprise only a small percentage of reported AIDS cases both in King County and nationwide, special medical services and public health campaigns are clearly indicated as well as culturally competent case management programs. HIV/AIDS prevention and treatment may be a low priority among AI/AN and AI/AN may be geographically isolated from prevention campaigns and up-to-date therapy. AI/AN may receive substandard health care due to poverty, lack of health insurance, or inadequate local facilities. Additionally, suspicion of Western medicine, the stigma associated with HIV risk, perceptions of substandard care in Indian health services, and the real lack of funding for such government services all may adversely affect an individual accessing health care services.

While only the significant differences between AI/AN and non-AI/AN are described here, there were several indicators in the local ASD study which suggest that the two groups have comparable outcomes. These include CD4 count, receipt of antiretroviral therapy, and receipt of PCP prophylaxis. Despite all of the impediments described above, the limited data available in the ASD cohort suggest that not all AI/AN have worse outcomes than non-AI/AN.

Thanks to Catherine Diamond, MD and the SKCDPH HIV/AIDS Epidemiology Unit for contributing to this report.

Vaccine Course

Mark your calendars for CDC's live four-part satellite course, *Epidemiology and Prevention of Vaccine-Preventable Diseases*, scheduled for **April 9, 16, 23, and 30, 1998**. The course is being co-sponsored by Overlake Hospital Medical Center in Bellevue. Each interactive broadcast will run from 9:00am to 12:30pm. The course will be taught by Dr. William Atkinson, a medical epidemiologist with the CDC. The primary focus of the sessions will be to provide updates on vaccine-preventable diseases, vaccine management and safety, and standard immunization practices.

Both private and public health care providers who either give immunizations or set policy for their offices or clinics, are encouraged to attend. CME/CEUs will be awarded to course participants who complete the training. Course fee is \$25.00. **SPACE IS LIMITED!!** Call Amy Patton, Administrative Specialist, SKCDPH, at (206)205-5803 for registration information.

REGISTRATION DEADLINE IS MARCH 31st.

To Report: (area code 206)
AIDS296-4645
Tuberculosis296-4747
STDs.....731-3954
Communicable Disease 296-4774
24-hr Report Line.....296-4782
Disease Alert:
CD Hotline296-4949
After hours682-7321
<http://www.metrokc.gov/health/>

REPORTED CASES OF SELECTED DISEASES SEATTLE-KING COUNTY 1998

	CASES REPORTED IN FEBRUARY		CASES REPORTED THROUGH FEBRUARY	
	1998	1997	1998	1997
VACCINE-PREVENTABLE DISEASES				
Mumps	0	0	0	0
Measles	0	0	0	0
Pertussis	24	25	39	56
Rubella	0	0	0	0
SEXUALLY TRANSMITTED DISEASES				
Syphilis	3	2	3	2
Gonorrhea	76	69	150	147
Chlamydial infections	300	265	554	526
Herpes, genital	52	54	106	108
Pelvic Inflammatory Disease	14	28	36	63
Syphilis, late	7	5	8	5
ENTERIC DISEASES				
Giardiasis	14	17	26	28
Salmonellosis	5	10	15	29
Shigellosis	6	8	11	15
Campylobacteriosis	16	19	34	49
E.coli O157:H7	0	1	1	2
HEPATITIS				
Hepatitis A	56	33	95	73
Hepatitis B	6	4	16	7
Hepatitis C/non-A, non-B	2	1	3	2
AIDS	21	29	47	44
TUBERCULOSIS	4	11	8	17
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae	0	1	0	1
Meningococcal disease	3	2	6	7