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Gonorrhea Trends

Among men who have sex with men (MSM), gonorrhea (GC) trends may reflect changes in sexual behaviors that also influence risk for human immunodeficiency virus (HIV) infection. Data from the Gonococcal Isolate Surveillance Project (GISP) were used by the Centers for Disease Control and Prevention (CDC) to assess GC trends among MSM. Results were recently published in the Morbidity and Mortality Weekly Report [MMWR 1997;46(no. 38):889-92].

GISP is a sentinel surveillance project begun in 1987 to monitor antimicrobial resistance in *Neisseria gonorrhoeae*. Through GISP, STD clinics in 26 U.S. cities collect gonococcal isolates and patient information, including sexual orientation, from the first 20 male patients with urethral GC each month. Surveys were conducted of the clinics where >5% of GISP isolates over the period 1993-96 were from MSM.

MSM comprised 5.0% of all GC cases in the GISP sample in 1993, a proportion similar to preceding years, and 8.7% in 1996 ($p<0.001$). Among the subset of eight GISP clinics, including Seattle, where >5% of isolates were obtained from MSM, the proportion increased from 12.0% (range: 4.2%-35.1%) in 1993 to 23.5% (range: 7.2%-57.1%) in 1996 ($p<0.001$). The median age of MSM reported from all 26 clinics was 30 years and remained stable from 1993 through 1996.

At two Seattle-King County Department of Public Health (SKCDPH) STD clinics, GC among MSM increased 125% (from 51 cases to 115 cases) from 1994 to 1996, while clinic visits by MSM increased by 17%. During the same period, the proportion of rectal and pharyngeal GC cultures that were positive among MSM at the Seattle clinics increased from 5.0% to 8.0% and from 1.5% to 6.7%, respectively. In addition, non-gonococcal, non-chlamydial urethritis increased 27% among MSM. Approximately one fourth of MSM with GC were HIV positive.

In the SKCDPH STD clinics during 1996, 42% of all GC cases in MSM were caused by a single gonococcal phenotype, likely to represent the successful spread of a single strain throughout the population. GC infections with this strain were linked with attendance at certain local clubs, anonymous sex partners, and the use of alcohol and other drugs. However, this strain has been infrequently isolated in 1997. During the first 6 months of 1997, GC cases in MSM declined by 66% (24 versus 72 cases) compared to the first 6 months of 1996.

The incidence of GC among MSM declined substantially in the United States and Seattle-King County during the 1980s as the HIV epidemic led to substantial reductions in sexual risk behaviors. Relapses in high-risk behavior among MSM, including unprotected anogenital intercourse have been reported. An increase in high-risk encounters among MSM could explain the increase in GC cases and could enhance the risk of HIV transmission. The presence of urethritis has been associated with an increased likelihood of HIV acquisition, and the presence of urethritis in persons with HIV increases the quantity of HIV in their semen and the likelihood of HIV transmission.

Although the incidence of GC in MSM in 1997 has declined in SKCDPH STD clinics, infections continue to occur. Each episode of GC in a MSM (or in a heterosexual man or woman) is a marker of unsafe sexual practices. The SKCDPH encourages health care providers to consider utilizing gonorrhea tests for patients who acknowledge risky sexual behaviors. Cases may be reported by calling (206) 731-3954. The management of sex partners with GC is a key component of control efforts. The SKCDPH has trained staff to assist with management and sexual safety counseling; they can be reached at (206) 731-4376. Persons who suspect they have an STD may be evaluated at the Harborview site (206 - 731-3590) or the Broadway site (206-720-4333). STD screening is also available in some of the SKCDPH district clinics.

Hepatitis C Exposure

Health care workers (HCWs) are at occupational risk for acquiring hepatitis C virus (HCV), although the seroconversion rate after unintentional needlesticks or sharps exposures has been low (range: 0-7%) in follow-up studies. These studies have not documented transmission associated with mucous membrane or nonintact skin exposures, but the transmission from a blood splash to the conjunctiva has been described in one case report. According to the CDC, the overall public health benefit associated with the identification of HCV infections in HCWs is thought to be limited due to the absence of 1) pre- or postexposure prophylaxis, 2) recommendations that are unique for HCV to prevent transmission to others, and 3) effective therapy for most persons with chronic HCV. However, the CDC, in collaboration with the Hospital Infection Control Practices Advisory Committee, recommends that individual health care institutions consider implementing policies and procedure for follow-up for HCV infection after percutaneous or permucosal exposures to blood in order to address individual workers' concerns about risk and outcome.

The recommendations are, at a minimum:

1) for source, baseline testing for antibody to HCV (anti-HCV);

2) for the person exposed to an anti-HCV-positive source, baseline

and follow-up (e.g., 6-month) testing for anti-HCV and alanine aminotransferase activity;
3) confirmation by supplemental anti-HCV testing of all anti-HCV results reported as repeatedly reactive by enzyme immunosassay;
4) recommending against postexposure prophylaxis with immune globulin or anti-viral agents (e.g. interferon); and
5) education of HCWs about the risk for and prevention of bloodborne infections, including HCV, in occupational settings, with the information routinely updated to ensure accuracy.

Six issues have been identified as those that, minimally, should be considered in defining a protocol for the follow-up of HCWs occupationally exposed to HCV:
1) limited data about the occupational risk for transmission,
2) limitations of available serologic testing for detecting infection and determining infectivity,
3) poorly defined risk for transmission by sexual and other exposures,
4) limited benefit of therapy for chronic disease,
5) cost of follow-up, and
6) medical and legal implications.

A fuller discussion of these issues may be found in the Morbidity and Mortality Weekly Report [MMWR 1997, 46 (no. 26):603-6]

HCV Teleconference

The CDC and the Hepatitis Foundation International are sponsoring an interactive satellite teleconference for physicians and other health care professionals entitled Hepatitis C: Diagnosis, Clinical Management, and Prevention on November 22, 1997, through the Public Health Training Network. The 2-1/2 hour conference will provide the most current information available on the epidemiology, diagnosis, treatment, and prevention of hepatitis C, referencing findings from the recent Hepatitis C Consensus Conference held at the National Institutes of Health. Application is being made for CME, CEU, CNE, CHES, and AAFP CEU credits. The speakers will include international experts on hepatitis C.

The registration cost is $25 for attendees which includes the course syllabus. To register, call (888) CDC-FAXX and request document #130010 to have registration materials faxed to you. Complete information about the conference, including site location and registration, is available online at http://www.hepfi.org or by writing the Hepatitis Foundation International, 300 Sunrise Terrace, Cedar Grove, NJ 07009; FAX: 201-857-5044 or by calling them at 1-800-891-0707. **You must register by November 1 to attend. There will be no registration at the door!** Space is limited so register early.

The teleconference will be held in King County at Overlake Hospital

Medical Center, Conference rooms C and D, 1035 116th Avenue NE, Bellevue, WA. The Conference Center and Conference Center Parking are located on the north side of the medical center. The site will be open at 8:30 a.m. for the arrival of program attendees. The teleconference will begin promptly at 9 a.m.

CDC Fax Info

The CDC International Fax Information Service is in transition to toll free service. In the interim, service will be provided from two telephone numbers. By dialing (404) 332-4565, one may request that the International Travel Directory be sent to a fax machine. This directory includes vaccine requirements and recommendations for travelers, with destinations grouped into 16 regions of the world. These regional documents may also be requested from the above number. In addition, by calling 1-888-232-3299, one may access directories on disease-specific topics, including those useful for international travel. These dual systems will operate until the transition to the 1-888 service is complete.

To Report:
AIDS 296-4645
Tuberculosis 296-4747
STDs..... 731-3954
Communicable Disease 296-4774
24-hr Report Line..... 296-4782
Disease Alert:
CD Hotline 296-4949

REPORTED CASES OF SELECTED DISEASES
SEATTLE-KING COUNTY 1997

	CASES REPORTED IN SEPTEMBER		CASES REPORTED THROUGH SEPTEMBER	
	1997	1996	1997	1996
VACCINE-PREVENTABLE DISEASES				
Mumps	0	1	3	3
Measles	0	0	1	4
Pertussis	14	28	151	184
Rubella	0	0	1	2
SEXUALLY TRANSMITTED DISEASES				
Syphilis	0	0	5	0
Gonorrhea	82	67	641	731
Chlamydial infections	216	223	2229	2511
Herpes, genital	60	37	501	506
Pelvic Inflammatory Disease	19	28	222	294
Syphilis, late	0	1	32	48
ENTERIC DISEASES				
Giardiasis	31	30	191	177
Salmonellosis	29	19	176	170
Shigellosis	11	9	82	50
Campylobacteriosis	30	30	257	249
E.coli O157:H7	8	6	35	31
HEPATITIS				
Hepatitis A	37	84	348	298
Hepatitis B	2	7	32	68
Hepatitis C/non-A, non-B	0	1	11	11
AIDS	39	30	249	349
TUBERCULOSIS	8	7	91	103
MENINGITIS/INVASIVE DISEASE				
Haemophilus influenzae	0	0	1	3
Meningococcal disease	1	0	16	21