

## Pulsed-Field Gel Electrophoresis Comparison of Pharyngeal and Sterile Site Group A Streptococcal Isolates

Surveillance for invasive cases of group A streptococcal (GAS) disease in Minnesota began in 1995 as part of the national Emerging Infections Program funded by the Centers for Disease Control and Prevention. For this surveillance system, an invasive case of GAS disease is defined by a positive culture for group A *Streptococcus* from a normally sterile site (e.g., blood, cerebrospinal fluid, joint fluid) or diagnosis of necrotizing fasciitis or streptococcal toxic shock syndrome with a positive culture for group A *Streptococcus* from any source. GAS isolates for invasive cases reported in Minnesota are submitted to the Minnesota Department of Health (MDH) Public Health Laboratory, which subtypes the isolates using pulsed-field gel electrophoresis (PFGE).

Previous studies have demonstrated commonalities among pharyngeal and invasive GAS isolates in epidemics of disease. During a community outbreak of invasive GAS disease in Minnesota in 1995, the predominant PFGE subtype among pharyngeal isolates from that community was the same as the invasive outbreak strain.<sup>1</sup>

In 1999, several clinics in Minnesota submitted a sample of their pharyngeal GAS isolates to MDH. The PFGE subtypes of these pharyngeal isolates were compared to subtypes from invasive GAS isolates collected through the surveillance system from the same geographic area during the same time period. The purpose of the comparison was to determine whether subtypes for pharyngeal and invasive

GAS isolates were similar in a non-outbreak setting. Antimicrobial susceptibility testing was performed for the pharyngeal GAS isolates submitted in 1999 and all invasive isolates beginning in 1998. Antibiotic resistance patterns were compared to PFGE subtypes for both invasive and pharyngeal isolates.

From January through May 1999, five clinics that routinely performed cultures for suspected streptococcal pharyngitis each submitted up to 30 consecutive pharyngeal GAS isolates per month to MDH for 4-5 months. One clinic was located in northern Minnesota, another was in the southern part of the state, and the remaining clinics were located throughout the Twin Cities metropolitan area. All of the invasive GAS isolates and roughly half of the pharyngeal isolates were subtyped using PFGE. The pharyngeal isolates represented a random sample from each clinic, proportionate to the percentage of invasive cases statewide that were submitted from the same facility or the closest hospital. The distribution of PFGE subtypes was compared for pharyngeal and invasive isolates statewide and by facility or region.

During this 5-month period in 1999, 108 invasive cases of GAS disease were reported in Minnesota. Isolates were available for 96 (89%) cases. Forty-three distinct PFGE subtypes were identified, 12 of which were represented by 2-12 isolates each, accounting for 68% of all invasive isolates. The remaining isolates each

had a unique PFGE pattern. During the same time period, 524 pharyngeal isolates were submitted, of which 246 (47%) were subtyped. Sixty-nine distinct subtypes were identified, with 26 subtypes represented by 2-71 isolates each, accounting for 82% of the pharyngeal isolates. The remaining isolates each had a unique PFGE pattern.

The distributions of PFGE subtypes among invasive and pharyngeal GAS isolates were similar in many respects. The most common PFGE subtypes among invasive cases were GA3 (13%); GA131, GA34, and GA86 (7% each); GA1 and GA5 (6% each); and GA2 (5%). The most common PFGE subtypes among pharyngeal isolates continued...

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were GA131 (29%); GA3 (10%); GA5 (7%); and GA1, GA2, and GA9 (4% each). The GA131 subtype accounted for 0-53% of pharyngeal isolates at each clinic. The other common subtypes were more evenly distributed among clinics. For example, the GA3 subtype accounted for 7-19% of isolates at each clinic.

Twenty-five invasive cases of GAS disease were reported from hospitals associated with clinics that submitted pharyngeal isolates (2-8 cases per site); 22 of these cases had an isolate available for subtyping. Sixteen PFGE patterns were identified among these case isolates, with three subtypes found at more than one facility. Fourteen (64%) of the 22 invasive cases for which isolates were available had PFGE subtypes also found among the pharyngeal isolates from the related clinic. A higher percentage of common invasive and pharyngeal subtypes might have been found if all pharyngeal isolates for each clinic had been submitted and subtyped.

All invasive GAS isolates submitted from 1998 through 2001 and the

pharyngeal isolates submitted in 1999 underwent antimicrobial susceptibility testing. All 605 invasive isolates were susceptible to penicillin. Twenty-three (4%) isolates were resistant to erythromycin. Two of the erythromycin-resistant isolates also were resistant to clindamycin. Ten (2%) of 524 pharyngeal isolates were resistant to erythromycin, but all were susceptible to clindamycin and penicillin. Eleven PFGE subtypes included isolates that were resistant to erythromycin. Four PFGE patterns accounted for 17 (65%) of 26 erythromycin-resistant isolates for which PFGE subtyping was available. Two isolates were untypeable, and the remaining isolates each had a different PFGE subtype. All of these remaining isolates, except one, had a PFGE subtype that was unique to a single isolate. Of the four PFGE subtypes with multiple erythromycin-resistant isolates, all of the isolates for three of the subtypes were resistant, while five (38%) of 13 isolates were resistant for the fourth PFGE subtype.

Overall, the most common PFGE subtypes for invasive GAS disease

also were the most common for GAS pharyngitis. While there was regional variability among some PFGE subtypes for both pharyngeal and invasive isolates, the same PFGE subtypes for invasive and pharyngeal isolates often were found in the same region.

Erythromycin resistance appears to be closely related to specific PFGE subtypes. Monitoring PFGE subtypes of pharyngeal isolates may be useful to detect the presence of highly virulent or pathogenic strains or strains that are more likely to be erythromycin-resistant. Monitoring PFGE subtypes of pharyngeal isolates also may be useful in the development of a vaccine to prevent GAS disease. A vaccine capable of preventing a large proportion of invasive disease also may be effective in reducing the incidence of GAS pharyngitis.

#### References

1. Cockerill FR, MacDonald KL, Thompson RL, *et al.* An outbreak of invasive group A streptococcal disease associated with high carriage rates of the invasive clone among school-aged children. *JAMA* 1997;277:38-43.

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## Proposed Change in Cancer Reporting Rules

The Minnesota Cancer Surveillance System (MCSS) is planning to amend rules governing the reporting of cancer diagnoses (Minnesota Rules, Chapter 4606). The most significant change will enable MCSS to begin collecting information on cancers that are not microscopically confirmed, in addition to the microscopically confirmed cases which have been reportable since 1988. MCSS also will require follow-up information on cancer patients.

Due to these changes, physicians will

report some cancer cases directly to MCSS. For example, if a clinician in private practice knows a cancer patient will not be seen at any facility that routinely reports to MCSS and no diagnostic specimen from the patient will be submitted to a laboratory in Minnesota, the clinician should report the case to MCSS. A reporting form soon will be available on MCSS's web site.

Comments, questions, and requests for a draft of the proposed rules or

further information should be directed to: Sally Bushhouse, D.V.M., Ph.D., Director, Minnesota Cancer Surveillance System, 717 Delaware Street SE, Minneapolis, Minnesota 55414; phone- (612) 676-5374; fax- (612) 676-5099; e-mail- sally.bushhouse@health.state.mn.us. TTY users may call (651) 215-8980. More detailed information about this change also can be viewed on the MCSS web site (<http://www.health.state.mn.us/divs/dpc/cdee/mcss.htm>).

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## Vaccine Supply Issues, 2002

### Background

Vaccine shortages are occurring throughout the United States and have affected vaccine supplies in Minnesota. Eight (possibly nine) of eleven vaccines used routinely to prevent vaccine-preventable diseases have been affected by the shortages. The affected vaccines include diphtheria, tetanus, acellular pertussis (Td, DT, and DTaP products); measles, mumps, rubella (M, M-R, and MMR); pneumo-

coccal conjugate vaccine (PCV7); and varicella. The Centers for Disease Control and Prevention (CDC) also has announced a possible decrease in the supply of *Haemophilus influenzae* type b (Hib) vaccine. Reasons for the shortages are numerous and complex.

### Vaccine Product Withdrawal

Several vaccine products have been withdrawn from the market, resulting in reduced supply by as much as 50% for

adult tetanus/diphtheria (Td) and pediatric diphtheria/tetanus/acellular pertussis (DTaP) products.

Manufacturers are not required to provide advance notice when they intend to stop production of a vaccine. Consequently, the government and others frequently do not have adequate time to react or to proactively plan for anticipated shortages.

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### **Thimerosal Preservative in Vaccines**

During the past 5-7 years, increased attention has been given to vaccine safety issues. In 1999, the Food and Drug Administration (FDA) released a report on thimerosal as a preservative commonly used in vaccines. The report concluded that certain combinations of vaccine schedules could expose an infant to enough thimerosal to exceed one of four national safety limits for accumulation of this element. As a result of this study, the U.S. Public Health Service and the American Academy of Pediatrics recommended that vaccine manufacturers eliminate or reduce the amount of thimerosal used as a preservative in vaccine products. This recommendation caused vaccine manufacturers to upgrade their production facilities in order to make vaccines in single-dose vials rather than the previously typical multi-dose vials. This change further delayed tight production schedules. Since vaccine vials customarily are slightly overfilled, the cumulative effect of switching from multi-dose to single-dose vials greatly increases the amount of overfill, thereby wasting more vaccine product and increasing manufacturing costs.

### **Good Manufacturing Practices (GMP)**

The FDA monitors vaccine manufacturers' compliance with appropriate production practices. This process is dynamic and changes with increasing demands for safety. Frequently, the production line for a particular vaccine must be shut down in order to make required GMP changes. Longer than anticipated shutdowns have occurred recently, thereby increasing vaccine shortages. The costs of keeping current with changing regulatory standards also can significantly impact manufacturers' financial conditions.

### **National Response to the Vaccine Shortage**

The shortage of vaccine products for eight of 11 vaccine preventable diseases has necessitated recommendations for interim changes in vaccination schedules. The Advisory Committee on Immunization Practices (ACIP), an advisory group for CDC regarding the use of vaccines, has altered recommendations for use of Td, DTaP, MMR, varicella, and pneumococcal conjugate vaccines. New recommendations include schedule changes or deferral of doses, usually those doses

intended to boost immunity (Table 1).

Additionally, eight senators have requested that the General Accounting Office (GAO) evaluate issues related to the national vaccine supply. The GAO will work with CDC and FDA to fulfill this request and expects to release its report to Congress in July 2002. The National Vaccine Advisory Committee, a 15-member committee which advises the Assistant Secretary for Health about immunization issues, also will address vaccine shortages in the U.S. A workshop with stakeholders was held in February 2001 in Washington, D.C. to discuss possible strategies to address these issues. The report has yet to be released but it is expected later this summer. However, issues that were discussed included: the feasibility of a national vaccine stockpile; restructuring financial incentives for manufacturers, particularly for research and product development; and streamlining FDA's regulatory processes. The Institute of Medicine met in May 2002 to evaluate "Vaccine Purchase Financing in the United States." This task will include developing a plan to ensure an adequate supply of current vaccines and to provide incentives for the development of new vaccines.

### **Minnesota Response to the Vaccine Shortage**

Through the "Got Your Shots" newsletter and several broadcast faxes, MDH has updated public and private providers throughout Minnesota regarding the vaccine shortage. These communications have included information on changes in ACIP recommendations, which can be accessed on MDH's web site (<http://www.health.state.mn.us/immunize>). The Minnesota Vaccines for Children (MnVFC) program has allocated vaccine commensurate to the ACIP recommendations in order to distribute vaccine to as many clinics as possible. In spite of reducing the quantities of orders, the MnVFC program has had no inventory of some vaccines for short periods.

Due to anecdotal reports of children not receiving vaccines in short supply at clinic visits, MDH is increasingly concerned about logistics of providers calling back children whose vaccinations have been deferred. In an effort to simplify call-back procedures, MDH developed a generic postcard on which

the clinic can fill in the type of vaccine for which the child was deferred and the parent can write in the child's contact information. These cards may be filed by antigen at the clinic and mailed when vaccine supply is available. MDH developed a simple two-page question/answer sheet which providers may distribute to parents and the general public, as necessary. Additionally, MDH established an information line with recorded information (612/676-4040) in February 2002 to provide ongoing and updated antigen-specific vaccine supply information.

MDH is currently surveying both private and public providers regarding the vaccine shortage's impact on their patient populations. Efforts to determine the impact on immunization rates and the potential for disease outbreaks also are being discussed.

### **Resolution of the Vaccine Shortage**

Predictions for when the vaccine shortage may resolve are continually changing and speculative. What seemed to be a promise of return to normal distribution of most vaccines by spring of 2002 has been extended.

MDH has had sporadic inventory of all vaccines involved in the shortages, including Td, DTaP, MMR, varicella, and pneumococcal conjugate vaccine. Recently, MDH's inventory of MMR, DTaP, and Td has increased. In May, the manufacturer for Td (Aventis Pasteur) sent letters to private health care providers inviting them to start ordering Td vaccine for use in wound management. In mid-June, 2002, the recommendation to defer routine booster doses of Td for adolescents and adults was discontinued. However, MDH's vaccine supply is not yet sufficient for large-scale catch-up of those whose vaccinations previously were deferred. Supplies of varicella vaccine are expected to stabilize by mid-summer. The Hib vaccine shortage likely will not resolve before late 2002. The pneumococcal conjugate vaccine shortage is not expected to resolve before the end of 2002. MDH will continue to update providers as new information becomes available.

Table 1 summarizes the current status and issues pertaining to individual vaccines.  
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**Table 1. Current Status of Specific Vaccine Products Affected by Vaccine Shortages**

Vaccine	Manufacturer Issues	ACIP Action	Minnesota Action
Td (adult formulation)	<ul style="list-style-type: none"> <li>• Aventis-Pasteur (API) is the sole producer of vaccine in the U.S., following the withdrawal of Wyeth-Ayerst-Lederle (WAL) TD in early 2001.</li> <li>• It takes 11 months to produce Td; the tetanus toxoid component also is the limiting factor in the production of Td, DTaP, T, DT (pediatric), and DTaP-HIB.</li> <li>• Adequate vaccine supplies are predicted to facilitate return to the routine schedule for Td boosters in late 2002.</li> </ul>	<ul style="list-style-type: none"> <li>• In early 2001, the ACIP recommended reserving Td for wound management, completion of a primary series, pregnant women who have not received a Td booster within the past 10 years, and international travelers to diphtheria-endemic countries. This recommendation continues into 2002.</li> <li>• In mid-June 2002, CDC announced that Td boosters for adolescents and adults may resume.</li> </ul>	<ul style="list-style-type: none"> <li>• Requirements for Td boosters for students in grades 7-12 have been suspended, as well as those for college students during the 2001-02 and 2002-03 school years. The 2002-03 suspension remains in effect to allow time for catch-up vaccinations.</li> <li>• MDH is not supplying MnVFC vaccine for use in large-scale clinics such as school booster clinics, health fairs, etc. MnVFC vaccine supplies are adequate to vaccinate the four categories of patients outlined in ACIP recommendations.</li> </ul>
DTaP	<ul style="list-style-type: none"> <li>• Two manufacturers, API and GlaxoSmithKline (GSK), are managing vaccine production since WAL and North American Vaccines ceased production of DTaP in early 2001.</li> <li>• Removal of the thimerosal preservative has resulted in less efficient production of vaccine.</li> <li>• API withdrew their federal contract for VFC vaccine and largely has been distributing vaccine only to the private sector. Maldistribution of vaccine is primarily affecting the public sector and private providers who depend on publicly purchased vaccines (e.g., through MnVFC).</li> </ul>	<ul style="list-style-type: none"> <li>• In March of 2001, the ACIP recommended that providers who do not have sufficient quantities of DTaP defer the fourth dose of the routine schedule; this recommendation continues into 2002.</li> <li>• Return to a full dosing schedule by all providers may not occur in 2002.</li> </ul>	<ul style="list-style-type: none"> <li>• No reduction at this time.</li> </ul>
Pneumococcal Conjugate Vaccine (PCV)	<ul style="list-style-type: none"> <li>• PCV was licensed in February 2000; WAL is the sole manufacturer of the vaccine (Prevnar).</li> <li>• Demand for vaccine has exceeded manufacturing projections. CDC estimates that immunization rates exceed 90% (compared to 68% for varicella vaccine, introduced in 1995). Large demand is the primary reason for the current shortage, which began in 2001 and continues into 2002.</li> <li>• In August 2001, WAL experienced problems producing Prevnar.</li> <li>• A return to the routine schedule with adequate vaccine supplies is not predicted.</li> </ul>	<p>In December 2001, the ACIP recommended deferring the fourth (booster) dose for healthy infants who receive their first dose before 6 months of age and the third dose for children who started the series at 7 months of age or later. If the shortage becomes severe, a two-dose schedule will be recommended for infants. Vaccination of all high-risk children (e.g., those with sickle-cell anemia or anatomic asplenia, chronic illness, or immunocompromising conditions, including HIV infection) less than 5 years of age should continue.</p>	<p>MDH reduces orders based on MDH inventory to try to maintain equitable distribution.</p>

Vaccine	Manufacturer Issues	ACIP Action	Minnesota Action
Varicella	<ul style="list-style-type: none"> <li>Merck is the sole producer of vaccine in the U.S.</li> <li>Merck voluntarily shut down their production line in the fall of 2001 for regular maintenance and to address GMP issues. The shutdown took longer than anticipated and led to production delays.</li> <li>Merck predicts that the supply of vaccine may be sufficient to return to the routine vaccination schedule by early summer of 2002.</li> </ul>	<p>The ACIP has recommended deferring primary vaccination of infants up to 18-24 months of age and prioritizing patients if the shortage becomes severe. High-priority patients include health-care workers, family contacts of immunocompromised persons, adolescents &gt;13 years of age, and adults and high-risk children (e.g., those with HIV infection, asthma, or eczema). Vaccination of susceptible children 5-12 years of age is a lower priority, particularly children entering school and adolescents 11-12 years of age.</p>	<p>There is a 30-business day or longer delay in the delivery of vaccine from Merck. As a result, many children and new immigrants are not receiving varicella vaccine.</p>
Measles, Mumps, Rubella (MMR)	<ul style="list-style-type: none"> <li>Merck is the sole producer in the U.S.</li> <li>Two voluntary interruptions in Merck's manufacturing in the fall of 2001 resulted in an MMR vaccine shortage and erratic inventory.</li> <li>Predictions indicate that routine shipments may resume by early summer 2002.</li> <li>CDC's stockpile of MMR has minimized the effects of the shortage.</li> <li>Single-antigen measles or mumps vaccines will not be available in 2002.</li> </ul>	<p>The ACIP has not recommended any change in the routine MMR vaccination schedule for infants. However, deferral of the 2nd dose given at 4-6 years of age is recommended if a provider does not have a sufficient vaccine supply.</p>	<p>MnVFC inventory has been erratic. Currently, MDH is filling all vaccine orders.</p>
Hib	<p>AVI has adequate supplies of ActHIB; however, both WAL (HibTITER) and Merck (PedvaxHIB) products are experiencing delays of &gt;30 days.</p>	<p>The ACIP has not recommended any change in the routine Hib vaccination schedule.</p>	<p>MDH has had no difficulty meeting MnVFC requests for Hib vaccine with ActHIB. While shipments of both HibTiter and PedvaxHIB to MDH are slower than those for ActHIB, requests still are being met using whichever product is available at the time of the order.</p>
Hepatitis B	<p>There have been no supply issues for the Engerix-B (SKB) product. Merck had difficulties supplying Recombivax HB products; however, this problem is now resolved.</p>	<p>The ACIP has not recommended any change in the routine hepatitis B vaccination schedule.</p>	<p>MDH is able to fill MnVFC vaccine orders for hepatitis B vaccine products.</p>

**Combination Product Status**

- TriHIBit (DTaP-HIB by API) is available in limited amount for those who depend on publicly purchased vaccine supplies.

- Some delays in filling COMVAX (HIB-HBV by Merck) orders will last at least through late summer.
- Two new combination vaccines under development are moving

closer to completion:

- DTaP-HBV-IPV (GSK)
- DTaP-HIB-IPV (API).

# Avoid Missed Opportunities to Prevent Hepatitis

Vaccines to protect against hepatitis B virus (HBV) and hepatitis A virus (HAV) infections have been available since 1982 and 1995, respectively. Many public health programs have been implemented in Minnesota to protect persons from these viruses; however, surveillance data indicate that cases continue to occur in persons with known risk factors. Identifying high-risk patients and offering vaccine could prevent such cases.

While the numbers of acute HBV infections reported to the Minnesota Department of Health (MDH) have decreased slightly over the past decade, the incidence of disease remains predominantly associated with high-risk sexual behaviors and injection drug use (IDU). Annual data collected on risk factors among HBV cases reported from 1991 to 1995 indicate that, on average, 50% of patients interviewed reported high-risk sexual contact, and 8% reported IDU. Comparable data for 1996 through 2000 show that, on average, 46% of cases reported high-risk sexual contact, and 5% reported IDU. Data on hepatitis A for 1996 through 2000 indicate, on average, that men who

have sex with men represented 12% of reported cases, despite national recommendations since 1995 to immunize this population against HAV.

Acute infections with hepatitis C virus (HCV) occur primarily in young adults, and hepatitis serology performed on these persons often shows susceptibility to HAV and/or HBV. Although there is no vaccine to prevent HCV infection, persons with behavioral risk factors should be counseled and vaccinated against HAV and HBV. Less than 1% of HCV infections reported to MDH in the past decade were diagnosed as acute infections annually; most reports represent chronic infections. On average, among the acute cases of HCV infection reported from 1996 to 2000, 43% reportedly were due to IDU, and 16% of case patients reported sexual contact as their only risk factor.

In light of these trends, clinicians are encouraged to collect sexual and substance abuse histories from patients, not only when seeing patients for hepatitis-like illness, but also during routine physical exams. This information is crucial to identify at-risk patients who would benefit from testing for past history of viral hepatitis infection and to

offer HAV and HBV immunizations to susceptible patients.

For example, a patient with history of IDU should be tested for hepatitis A, B, and C. If the HCV test is positive and markers for hepatitis A and B are negative, the patient may be offered HAV and HBV vaccines and referred to a specialist for follow up of HCV infection. A patient who presents with no history of IDU but with a history of multiple sex partners or sexually transmitted infection(s) should be asked about the gender of sexual partners and tested for hepatitis A and B. If the patient has engaged in male-to-male sex, he should be vaccinated for HAV and HBV, if susceptible.

Patient education materials on viral hepatitis are available on several web sites, including <http://www.immunize.org>, <http://www.health.state.mn.us/hepatitis> and <http://www.cdc.gov/hepatitis>. Tools are available to assist clinicians with decisions regarding ordering and interpreting serologic testing for hepatitis and providing vaccinations. MDH staff are available at (612) 676-5237 for consultation regarding hepatitis.

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## Sexually Transmitted Diseases: Treatment Guidelines, 2002

The Centers for Disease Control and Prevention (CDC) recently issued updated guidelines for treatment of sexually transmitted diseases (STDs). The *2002 Guidelines for the Treatment of Sexually Transmitted Diseases* integrate recommendations on treatment regimens, screening procedures, and prevention strategies for STDs, which infect an estimated 15 million people each year in the United States. The complete guidelines are available on CDC's web site (<http://www.cdc.gov/std>). Additions and revisions in the new guidelines include the following:

### **Recommendation for Expanded Screening for Chlamydia Among Women**

The new guidelines advise health care providers to screen sexually active adolescent (19 years of age or younger) and young adult (20-24 years

of age) women for chlamydia annually, even if symptoms are not present, and to screen older women with risk factors for chlamydia (e.g., a new sexual partner or multiple sexual partners). CDC now recommends that all women with chlamydia infection should be rescreened 3-4 months after completing treatment. This is the first time CDC has recommended rescreening for chlamydia.

### **Alternative Treatments for Gonorrhea Following Increasing Drug Resistance in California**

Drug-resistant cases of gonorrhea are becoming increasingly common in the U.S. When ciprofloxacin-resistant gonorrhea was found to be endemic in Hawaii in 2000, CDC recommended that physicians in that state should cease using the fluoroquinolone antibiotics ciprofloxacin, ofloxacin, and levofloxacin to treat gonorrhea. CDC

now warns providers that ciprofloxacin-resistant strains of gonorrhea have become so common in California that the use of fluoroquinolone antibiotics to treat gonorrhea also is inadvisable in California. Cefixime and ceftriaxone now are recommended as first-line drugs to treat gonorrhea in Hawaii and California. Recommendations for treatment of gonorrhea in Minnesota have not changed and include:

- cefixime, 400 mg orally in a single dose, or
- ceftriaxone, 125 mg IM in a single dose, or
- ciprofloxacin, 500 mg orally in a single dose, or
- ofloxacin, 400 mg orally in a single dose, or
- levofloxacin, 250 mg orally in a single dose.

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### **Need for Expanded Risk Assessment and Screening Among Gay and Bisexual Men**

Recent data in many U.S. cities indicate an increased frequency of unprotected sex and increased rates of syphilis and gonorrhea among men who have sex with men (MSM), many of whom are HIV-infected. This trend includes the Twin Cities metropolitan area in Minnesota, where the incidence of syphilis among MSM has increased in 2002 (see the related article in this issue). These trends highlight the critical need for health care providers to expand screening and treatment of STDs among MSM.

The updated STD treatment guidelines urge health care providers to assess sexual risk factors, including the gender of sexual partners, for all male patients. For sexually active MSM, the guidelines recommend annual screening for HIV, chlamydia (anal, urethral), syphilis and gonorrhea (anal, pharyngeal, urethral), and vaccination against hepatitis A and B. More frequent screening for STDs may be indicated for those who report having multiple

anonymous sexual partners or having sex in conjunction with illicit drug use.

### **New Serologic Tests Available to Diagnose Genital Herpes**

New testing procedures may help providers diagnose and manage genital herpes type one (HSV-1) and type two (HSV-2). Since antiviral therapy may benefit individuals with symptoms of herpes, providers who know their patients' viral serotypes should tailor counseling and treatment plans to best fit their needs.

Most individuals with recurring genital herpes outbreaks are infected with HSV-2, which almost always is spread via sexual contact. Patients infected with HSV-2 may choose from suppressive or episodic antiviral treatments which can prevent or shorten the duration of outbreaks. Genital HSV-1, which often is caused by oral-genital sexual contact with a person with an oral HSV-1 infection (e.g., fever blister), is much less likely to recur; treatment may be needed only for patients with initial symptoms.

Regardless of the severity of symptoms, genital herpes frequently causes psychological distress in persons who know they are infected. The new CDC guidelines urge providers to counsel symptomatic patients with HSV-1 or HSV-2 about the diseases, the initial and recurring manifestations, and how to avoid transmission of the virus to sexual partners and newborns. The latter is especially important since HSV can cause potentially fatal infections in infants if the mother is shedding the virus at the time of delivery, particularly if the maternal infection was acquired recently.

### **Prevention of STDs**

The CDC guidelines encourage health care providers to focus on risk assessment and counseling, in addition to the clinical aspects of screening, treatment, and control of STDs. To assist providers with prevention efforts, clinical prevention guidelines have been expanded in 2002. Providers are encouraged to use client-centered counseling approaches tailored specifically for each patient.

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## **Increasing Incidence of Syphilis in Minnesota, 2002**

An unexpected increase in the number of cases of syphilis reported among men who have sex with men (MSM) recently has been documented in Minnesota. Statewide, 14 (67%) of 21 syphilis cases reported in Minnesota during 2002 have occurred among MSM, compared to two (10%) of 20 cases reported during the same time period in 2001. Most of the cases reported among MSM reside in Hennepin County. The case patients are men ranging in age from 27 to 62 years. Half of these cases are co-infected with HIV.

The majority of the cases were diagnosed during the primary or secondary stage of disease, suggesting that these individuals noticed the initial characteristic symptoms (e.g., sores on or near the genitals or rashes) and consequently sought medical care. The large proportion of cases diagnosed at an early stage suggests that the infections were acquired recently through unprotected sex. This emphasizes the great need to alert the patients' sexual partners of the need for screening, diagnosis, and treatment. The Centers for Disease

Control and Prevention recently issued the updated recommendations, *2002 Guidelines for the Treatment of Sexually Transmitted Diseases*, which call for annual screening for STDs among sexually active MSM and more frequent screening (every 3-6 months) for MSM who engage in anonymous sex (see related article in this issue). An image library of lesions of STDs, including syphilis, is available at <http://www.stdptc.uc.edu/PTCs/Cincinnati/images5.cfm>.

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## **Redesigned Library Web Site**

The Minnesota Department of Health (MDH) Library's new web site at <http://www.health.state.mn.us/library/library.htm> has been updated with new and useful features designed to provide easy access to the Library's books, electronic journals, newsletters, newspapers, videotapes, and reference materials. The new features include:

- direct access to all MDH on-line newsletters;
- links to all of MDH's on-line journals, as well as links to on-line journals available free of charge;
- a searchable catalog of public health videotapes for professionals and general audiences;
- links to PubMed and other on-line journal article indices;
- numerous on-line reference sources, including medical dictionaries, medical books, encyclopedias, consumer health databases, and legislative materials;
- easy-to-use order forms for MDH pamphlets; and
- a searchable database of the Library's books and MDH publications.

# Childcare and School Immunization Rule Update

The Minnesota Department of Health (MDH) is considering a new rule that will modify the current child care, school, and college immunization laws (Minnesota Statutes, sections 121A.15 and 135A.14). MDH will hold Advisory Committee meetings for the public on the proposed rule. The first meeting is scheduled for Wednesday, July 24, 2002, from 5:30 p.m. to 8:00 p.m. at Snelling Office Park, 1645 Energy Park

Drive, St. Paul, MN 55108. For directions to the meeting, go to the web site listed below. MDH will publish a "Request for Comments" at the beginning of July to solicit public input on the proposed rule. This request will be published on the web site and in the Minnesota State Registry. For further information on the rule and the rulemaking process, contact:

Patricia Segal Freeman, Minnesota Department of Health, PO Box 9441, Minneapolis, MN 55440-9441; phone (612) 676-5237 or 1-800-657-3970; fax (612) 676-5689; TTY users may call MDH at (651) 215-8980; e-mail [ImmunizeRule@health.state.mn.us](mailto:ImmunizeRule@health.state.mn.us); web site <http://www.health.state.mn.us/divs/dpc/adps/immrule.htm>.

## Jan K. Malcolm, Commissioner of Health

### Division of Infectious Disease Epidemiology, Prevention and Control

Harry F. Hull, M.D. .... Division Director & State Epidemiologist  
Richard N. Danila, Ph.D., M.P.H. .... ADIC Section Manager  
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