



Yakima Health District BULLETIN

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Summary of 2005 Sexually Transmitted Diseases Morbidity

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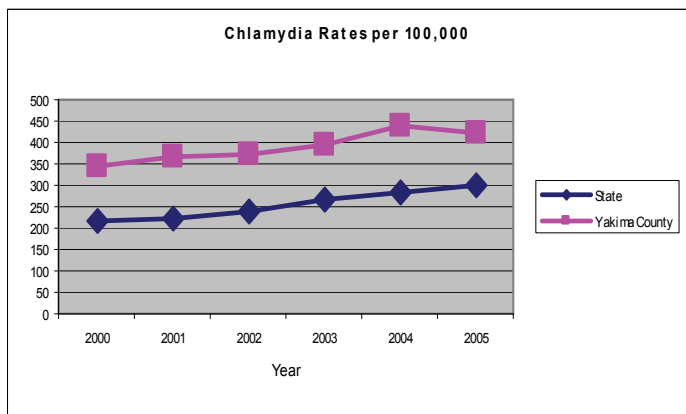
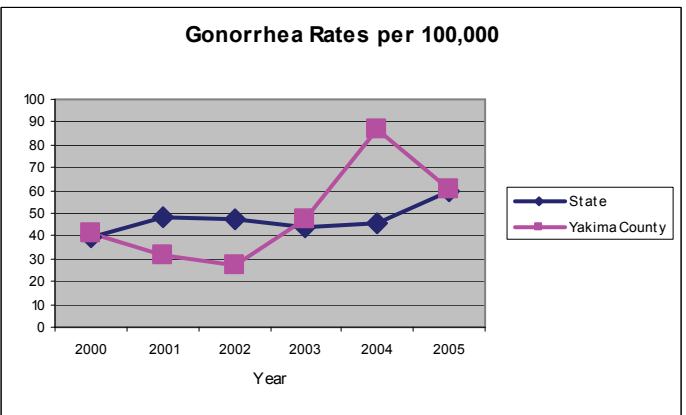
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Chlamydia infections continue to be the overall leading STD and notifiable condition in Yakima County, with 973 cases reported in 2005. This is essentially unchanged from 2004 data and represents a case rate of ~425 per 100,000 residents (vs. ~300/100,000 state-wide). Reported cases to date for 2006 are about 10% higher than in 2005. In 2005, about 60% of infections were detected through screening of asymptomatic young women and men. About two-thirds of chlamydia infections are asymptomatic in women; only one-third are asymptomatic in men. Screening positivity rates in reproductive health clinics continues to be about 10%. Most infections, and the highest rates, occur among adolescents and adults aged 15-24 years. Chlamydia remains an important target for prevention efforts because of its association with pelvic inflammatory disease and post-inflammatory sequelae that include ectopic pregnancy, infertility, and chronic pelvic pain. Nine percent of reported cases represented re-infection (i.e., record of a prior chlamydia diagnosis within the preceding 12 months); Repeat infections have been associated with higher risk of such sequelae in the medical literature. Gonorrhea cases declined 30% from 198 cases in 2004, to 139 cases in 2005. Yakima County's gonorrhea rate (60/100,000) is similar to that for the entire state of Washington. Reported cases to-date (156) for 2006 are about 20% higher than in 2005. In 2005, about 90% of cases among men were symptomatic; 60% were symptomatic among women. Screening positivity rates in reproductive health settings are about 1%. As for chlamydia,

adolescents and young adults are the age groups most commonly infected, but the peak age is shifted about 5 years older for gonorrhea. Repeat infections accounted for four percent of reported cases.



Only three cases of early syphilis were reported in Yakima County and there appears to be no ongoing transmission in Yakima County. Syphilis transmission among men who have sex with men continues to be a problem in Seattle, so providers should remain alert for importation or acquisition from that part of the state. About 100 cases of initial genital herpes infection were reported. While this probably represents an underestimate of true genital HSV incidence, it clearly indicates that sexual transmission of HSV is ongoing. Fourteen cases of newly diagnosed HIV infection were reported, similar to recent years. Because HIV transmission is associated with the concomitant presence of these exudative and ulcerative STDs, their control is a key component of HIV prevention efforts in addition to preventing the suffering and sequelae associated with the diseases themselves. Your partnership in screening, diagnosing, and treating STD's, and in following-up on cases' sexual partners, is greatly appreciated. To report STD cases, to obtain consultation on patient management and follow-up, or to get more information about STDs in Yakima County, please contact Alex Popov at (509) 249-6531. To directly view the Washington State Department of Health's recent STD Profiles for Yakima County, please visit: <http://www.doh.wa.gov/cfh/STD/countyprofileyr.htm#Yakima>

CDC Releases Updated STD Treatment Guidelines

In August 2006, the Centers for Disease Control and Prevention, with consultation and guidance from national experts, released an updated version of its STD Treatment Guidelines. This publication is an outstanding reference not only for standard diagnosis and treatment of STDs, but also for background discussions on epidemiology, transmission, and prevention. All providers of primary and reproductive health care are encouraged to keep these guidelines readily available in print or electronic version. They can be viewed or downloaded at <http://www.cdc.gov/std/treatment/>.

Key features or changes in the updated guidelines include:

- the latest information on screening, diagnosis, treatment among men who have sex with men;
- new recommendations for follow-up screening at three months to detect re-infection among patients who have chlamydia and gonorrhea;
- regimens for prevention of HSV recurrence and transmission;
- emergence of quinolone-resistant gonorrhea
- recommendations for patient delivered partner therapy for gonorrhea and chlamydia;
- management of recurrent or severe vulvovaginal candidiasis.

A table of summarizing standard therapeutic recommendations for the most common STDs can be obtained by contacting Alex Popov at 249-6531.

Joint Select Committee on Public Health Financing Report

At one time, county governments were obligated to spend 21.5 cents per \$1000 of local property tax revenues on tuberculosis control and public health, but this statutory restriction was repealed in 1977. You may recall that from 1994-2000, prior to repeal of the motor vehicle excise tax, 2.95% of the motor vehicle excise tax was dedicated to local public health. Subsequent to its repeal, the legislature has had to "backfill" these lost revenues each session to maintain local public health capacity; but no long term solution has been enacted to address this problem. Earlier this year, the Washington State Legislature convened a Joint (House and Senate) Select Committee on Public Health Finance to review the status of existing public health funding and make recommendations for the future.

The Committee found that nearly \$600 million dollars were spent on public health services statewide in 2004. About 50% of this spending was by local public health jurisdictions, who get about 75% of their funding from local sources. Spending was for health promotion (44%), assisting people with gaining access to medical and dental care (15%), assuring safe food and environments (13%), control of communicable diseases (12%), and epidemiology and other assessment activities (6%). Administration accounted for 10% of expenses.

The Committee also found that there is little state or local revenue specifically dedicated to public health. User fees (e.g., for permits and services) are the leading revenue source (46%), followed by local tax dollars (26%), federal grants (16%), and state tax dollars (13%). The state tax dollar investment in public health represents only about 3% of the amount spent by the state on health care.

Of the 18% (post-inflation) growth in overall public health system spending from 1998-2004, 70% was attributable to growth in federal funding. These dollars contain virtually no flexibility; they must be spent specifically on the categorical activities for which they are granted. Another 13% of the growth was due to increased fees for permits and services. On a statewide basis, spending of local tax dollars on local public health jurisdiction activities decreased by 15% after adjustment for inflation. Key factors influencing this latter trend are increasing criminal justice costs (now 66% of all local spending) and the 1% per annum limit on growth of property taxes imposed by Initiative 747. Considerable variation in local government contributions was noted (median: \$7/person*year; range \$2-35). These variations were attributed to differences in tax bases, criminal justice costs, and level of demand. Models of service delivery can also affect these figures, as well, depending on whether local funds for public health services are designated to agencies other than the local public health jurisdiction itself.

The Committee concluded that funding of local public health services is a joint state-local responsibility and that there is a need for additional investment in local public health services, particularly in communicable disease control, emergency preparedness, prevention of chronic disease morbidity, maternal-child health services, and data collection and analysis. Last, they stated that the lack of a stable source of specific funding has eroded the ability of local health jurisdictions to maintain a reliable statewide public health system.

Therefore, the Committee recommended that the state should increase its investment by approximately \$50 million per year through a stable and dedicated funding source(s). Local governments would have to maintain current levels of investment to be eligible for additional state funding.

The Committee's complete report can be viewed or downloaded at: <http://www1.leg.wa.gov/documents/joint/PHF/FinalReport.pdf>

For more information or to express your thoughts regarding local public health funding please contact your elected Washington State legislators. Dennis Klukan, MSEP, YHD Administrator, can also be reached at (509) 249-6666 for discussion regarding this topic.

Thank You

Thanks to Alexia Exarchos, MPH, Assessment Unit, Office of Infectious Diseases and Reproductive Health, Washington State Department of Health, for generating the data included in the report *Tuberculosis Morbidity in Yakima County, 2003-2005* from the September issue of the Yakima Health District Bulletin.

Medical Wastes

Our agency is routinely asked about how medical wastes may be properly disposed of. One option is to contract with a regulated solid waste handler. Doing it yourself is still feasible, but standards for safe disposal have been raised. Some time ago, state regulations changed, disallowing the disposal of containers of medical wastes through processes where the container will be crushed (i.e., where the disposal service utilizes a compactor truck). Still allowed is the self-hauling of any medical waste to a landfill. Both Yakima County solid waste landfills (Terrace Heights and Cheyne) accept medical waste. Self-hauling involves transporting the waste containers directly to the landfill by those generating the waste and identifying the material as medical waste to the scale house attendant. You will then be directed to a special area of the disposal site where the containers can be placed. The site workers will then take special precautions in the further processing of this material. There is an additional special handling fee payable at the landfill for the disposal of this material.

If you have additional questions, please contact our Environmental Health help desk at 249-6508.

Methicillin-Resistant *Staphylococcus aureus* as Community Pathogen

Although not formally a notifiable condition in Washington State, YHD is becoming aware of more cases and clusters of community acquired MRSA (CA-MRSA). This reflects a nationwide trend of increased incidence and invasiveness of CA-MRSA. Results from one recent study suggest that CA-MRSA may account for over one-half of acute purulent skin and soft tissue infections. Preliminary reports suggest that up to 40-50% of *S. aureus* isolates in Yakima County in 2006 were resistant to methicillin. Clusters of cases and outbreaks can occur in any setting where close contact is common; reported settings have included athletic teams and facilities, military personnel, childcare centers, and correctional facilities. Although individual cases are not notifiable conditions, suspected outbreaks should be reported. Management of outbreaks involves active surveillance for skin lesions, standardized diagnosis and treatment, hygiene education, and environmental cleaning.

Microbiologic and molecular investigations have determined that CA-MRSA evolved independently from nosocomial MRSA; it did not arise from it. Unlike its nosocomial counterpart, CA-MRSA frequently retains susceptibility to non-beta lactam antibiotics. Due to the presence of genes for toxins not found in nosocomial strains, it appears to be more prone to cause invasive disease, as well. As the CA-MRSA epidemic expands, the difference between the two will become blurred. Dominant circulating CA-MRSA clones have already been detected among MRSA cases in health care facilities.

In its next Bulletin, YHD will report on what is known about the anti-microbial susceptibility patterns of local *S. aureus* isolates. Meanwhile, guidelines on recognition, evaluation, and management of CA-MRSA can be found at:

<http://www.doh.wa.gov/topics/antibiotics/Documents/MRSAinterimGuidelines.pdf>

http://www.cdc.gov/ncidod/dhqp/pdf/ar/CAMRSA_ExpMtgStrategies.pdf

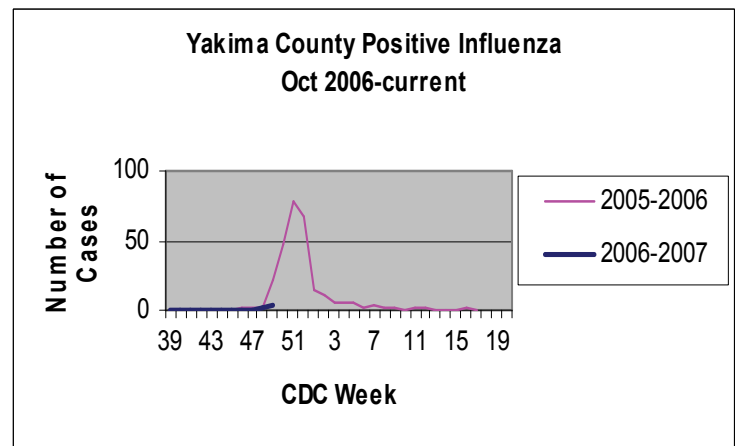
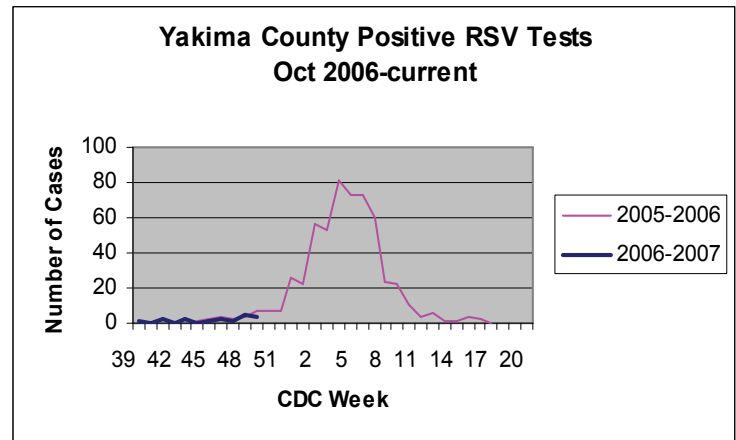
RSV/Influenza Update

RSV has been circulating in Yakima County for about one month, and several cases of influenza (5 positive influenza "A") have been detected during the past two weeks. This information comes from sentinel surveillance conducted in partnership with several local hospital laboratories.

Results are posted on the YHD website www.yakimapublichealth.org and are updated weekly.

Treatment and chemoprophylaxis tables for anti-influenza agents can be viewed on the YHD website by clicking on RSV & Flu Stats and scrolling down to the links on the bottom of the page. **Due to the finding of rimantidine/amantidine resistance among dominant circulating influenza viruses detected by national and global surveillance, these agents are not currently recommended for treatment of influenza A, influenza B, or influenza-like illness.**

Children under 2 years of age with risk factors for severe RSV disease (pre-term infants, chronic lung disease) are eligible for palivizumab prophylaxis while RSV is circulating in the community. For more specific details on indications and usage, go to the YHD website and click on RSV & Flu Stats, again scrolling down to the bottom of the page.



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Notifiable Conditions Summary Jan-Nov, 2006

Condition (includes confirmed and probable cases)	Cases			Total Cases by Year	
	Jan-Nov	Jan-Nov	Jan-Nov	Total Cases by Year	Total Cases by Year
	2006	2005	2004	2005	2004
Campylobacteriosis	202	108	92	115	99
Cryptosporidiosis	7	7	2	7	2
Enterohemorrhagic E. coli	5	3	3	3	3
Giardiasis	25	26	30	28	30
Salmonellosis	35	49	33	49	36
Shigellosis	37	23	7	25	7
Hepatitis A acute	1	3	2	3	2
Hepatitis B acute	4	1	4	1	4
Hepatitis B chronic	11	12	21	14	22
Hepatitis C acute	2	1	2	1	2
Hepatitis C chronic	171	193	210	214	219
Meningococcal	1	0	1	2	3
Pertussis	22	193	57	197	62
Tuberculosis	15	14	12	14	12
HIV New	3	9	12	14	12
HIV Deaths	0	2	1	2	1
HIV Cumulative Living	143	135	128	140	128
Chlamydia	1027	890	923	973	1002
Genital Herpes—Initial	65	91	113	99	125
Gonorrhea	156	120	185	138	198
Primary and Secondary Syphilis	3	1	0	2	0