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Gonococcal Infection Update — Alaska, 2011

Background

Preliminary data for the first 3 quarters of 2011 show a decrease in the number of gonococcal (GC) cases reported to the Section of Epidemiology (SOE). Alaska's recent spike in gonorrhea incidence was first discovered in the Southwest region in 2008,¹ and this increase continued over the next 2 years across all regions of Alaska.^{2,3} By 2010, Alaska's GC rate was the third highest in the nation. The purpose of this *Bulletin* is to provide an interim status report for health care providers and other stakeholders.

Untreated GC is a major cause of pelvic inflammatory disease, ectopic pregnancy, and infertility among women; epididymitis and infertility in men; and conjunctivitis among neonates. GC infection also increases the likelihood of transmission of human immunodeficiency virus (HIV).

In 2010, SOE collaborated with federal, state, and local health partners in GC outbreak response activities, which led to recommendations that providers implement expedited partner therapy (EPT) to help control the epidemic.⁴ A complete description of this investigation is detailed in a companion *Recommendations and Reports*.⁵

Methods

Case data were obtained from the SOE reportable conditions database; data were analyzed using MS Excel 2007. The number of GC tests performed in 2010 and 2011 at the Alaska State Public Health Laboratory (ASPHL) were also reviewed.

Results

There has been a 23% decrease in the number of GC cases reported during the first 3 quarters of 2011 (n=770) compared to the first 3 quarters of 2010 (n=1,005; Figure 1). This reduction occurred among all racial groups, with the most sizeable decreases occurring among American Indian/Alaska Native people (AI/AN; 24%) and whites (31%; Figure 2).

Figure 1. Gonorrhea Case Reports, by Quarter — Alaska, January–September 2008–2011

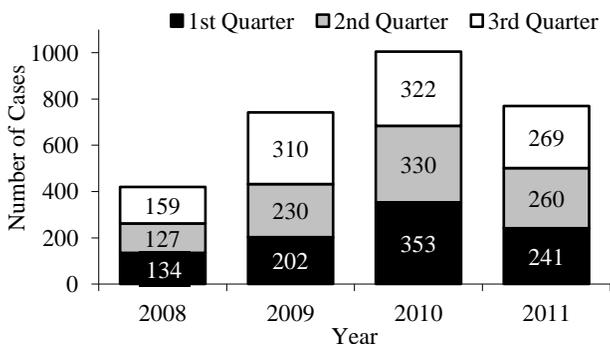
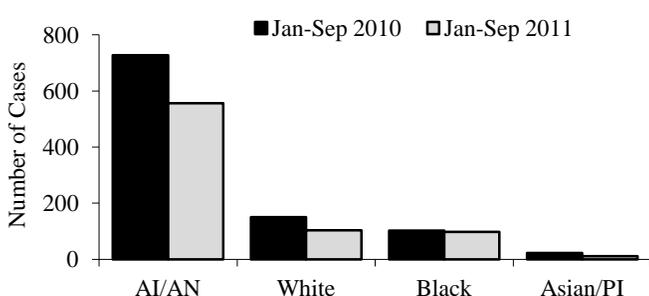


Figure 2. Gonorrhea Case Reports, by Race — Alaska, January–September 2010 (N=1,005) and 2011 (N=770)*



*Four cases in 2010 and 2 cases in 2011 were of undetermined or other race and are not included in this figure.

Case counts decreased by 15–42% during the first 3 quarters of 2011 compared to the first 3 quarters of 2010 in all economic regions of Alaska except the Interior, where case counts increased by 50%, from 126 in 2010 to 189 in 2011.

There was a 2% decrease in the number of clinical specimens submitted to ASPHL for GC testing during the first 3 quarters of 2011 (n=28,279) compared to 2010 (n=28,918).

Discussion

The number of reported GC cases decreased substantially during the first 3 quarters of 2011 compared to the first 3 quarters of 2010. Factors that likely contributed to the decrease include the following: (1) increased prioritization of GC partner notification services statewide; (2) increased awareness of the GC epidemic among providers and perhaps increased empiric GC treatment; (3) increased utilization of EPT in many regions of the state;⁴ (4) new availability of vaginal swab testing capacity at ASPHL in 2011; and (5) decreased GC testing at ASPHL in 2011 compared to 2010 (this decrease was slight [2%] and likely was not a substantial contributor to the decreased case counts in 2011).

While these data are encouraging, health care providers need to remain vigilant about controlling this GC epidemic. Since co-infection with *Chlamydia trachomatis* (CT) is common, patients treated for GC should also be treated for CT. Similarly, if sexual contacts to GC-infected patients are not tested or test negative for CT by a non-nucleic amplification test, they should be treated for both GC and CT.⁶

Recommendations

1. Health care providers should promptly treat GC-infected patients with a CDC-recommended drug regimen (i.e., ceftriaxone 250 mg IM and Azithromycin 1 g PO as co-treatment for CT infection and to hinder the development of antimicrobial-resistant *N. gonorrhoeae*).⁶
2. Test all persons who are infected with GC for other STDs, including HIV.
3. Strongly encourage patients with GC infection to participate in partner notification services, including confidential and timely notification of all sex partners.
4. Consider using Cefixime 400 mg PO with Azithromycin 1 g PO as EPT to treat sex partners of patients diagnosed with GC, particularly when other partner management strategies are unavailable or unlikely to be successful.
5. For more information about the distribution of GC and CT infection throughout Alaska, refer to the new online interactive mapping program.⁷
6. Report confirmed or suspected cases of GC and CT infection and treatment information to SOE within 5 working days via fax at 907-561-4239 or telephone at 907-561-4234 or 800-478-1700. The reporting form can be found at www.epi.alaska.gov/pubs/conditions/frmSTD.pdf

References

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