State of California—Health and Human Services Agency
Department of Health Services

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Dear STD Controllers:

I am sending you this information in order to assist you in your sexually transmitted disease (STD) control efforts.

Lymphogranuloma venereum (LGV)

As I informed you on October 27, there was an outbreak of lymphogranuloma venereum (LGV) in the Netherlands among men who have sex with men (MSM) in 2003-04.

Since June 2004, several cases have been identified in the U.S., including at least one in San Francisco. We anticipate that the press may be reporting on these cases in the next few weeks and want to make sure you have this information to respond to any enquiries.

The Centers for Disease Control and Prevention (CDC) and the California STD Control Branch are concerned about the possibility of identifying further cases in California and elsewhere. However, at this time we know neither the magnitude of the problem nor the most practical and resource-effective approach to case detection. Given the ulcerative nature of this more invasive chlamydial infection with its presumed higher risk of facilitating HIV transmission, as well as the level of STD co-infection and the associated hepatitis C infection seen in the Netherlands outbreak, concern is high for the potential adverse health effects if this infection re-emerges in the U.S.

Dr. Chris Hall of the STD Control Branch is preparing several tools that will assist STD Controllers and clinicians in recognizing, diagnosing, managing, and reporting suspected cases of LGV, including a clinical primer, management algorithm for suspected cases, and resources for diagnostic testing that may not be available locally. A “Suspected Case Report Form” specific to California has been developed for use. All related documents will be posted on the California STD/HIV Prevention Training Center (CA PTC) website at:

http://www.stdhivtraining.org/lgv/

Given what is known, the following are key points for providers in California:

1. Providers need to ask patients about gender of sex partners and assess behavioral risk which may result in sexually transmitted infections. For LGV, based on the epidemiology of the Netherlands outbreak, risk is primarily unprotected anal intercourse and/or other anal penetration such as fisting.
2. Clinicians who care for MSM should consider LGV in the diagnosis of compatible syndromes: 1) proctitis/protocolitis which can be hemorrhagic and associated with constitutional symptoms or 2) tender inguinal lymphadenopathy associated occasionally with bubo formation and rarely with the presence of a painless genital ulcer. Clinicians should obtain serologic and microbiologic tests that diagnose *C. trachomatis* (CT) infections, including LGV.
3. The following two types of tests are recommended for the diagnosis of a suspected LGV case: 1) a serologic test (e.g., microimmunofluoresence (MIF) or complement fixation (CF)) and 2) a microbiologic test, either chlamydia tissue culture or Nucleic Acid Amplification Test (NAAT) on rectal specimens (anoscopy-directed specimens from ulcerative lesions are preferred over blind swabs) or on specimens from bubo aspirates or ulcerative lesions in the presence of inguinal lymphadenopathy. Other serologic tests such as the immunofluorescence antibody (IFA) and enzyme immunoassay (EIA) should be avoided since they are less specific and/or cannot be quantitated.
4. Suspected cases should be reported to local health departments by both provider and laboratory. Providers should report within 24 hours after the patient is seen, if the patient was presumptively treated. Otherwise, providers should report within 24 hours after the test results are available. Laboratories should report within 24 hours after the test results are available. A “Suspected LGV Case Report Form,” available at the Web site above, should be completed. Until we have a better understanding of the epidemiology and clinical features of this infection, we are defining a suspected case as “any MSM with a compatible syndrome (e.g., proctitis or inguinal lymphadenopathy) and a positive lab test suggestive of a LGV infection (i.e., an MIF test with a titer of greater than 1:128 or a CF test with a titer of greater than or equal to1:64 and/or a positive tissue culture or a NAAT test from a rectal specimen, bubo, or ulcer in the presence of lymphadenopathy).”
5. The recommended treatment for LGV is a three-week (21-day) course of oral doxycycline 100 mg twice daily. Though data are lacking, some experts suggest that azithromycin (1 gm orally in three weekly doses) is also effective in treating LGV.
6. While testing for CT/LGV is important in all suspected cases, providers should exercise clinical judgment in initiating presumptive treatment for LGV. They should consider factors such as severity of rectal symptoms in proctitis, presence

of systemic symptoms that make LGV a more likely diagnosis, travel and exposure in Europe, and likelihood of follow-up.

7. Sex partners should be offered appropriate partner management services. Those with sexual contact within 60 days should be clinically evaluated and if symptomatic, managed as above. If asymptomatic, they should be treated with either oral doxycycline 100 mg twice daily for seven days or a single 1-gram oral dose of azithromycin.
8. In patients with suspected LGV, screening is warranted for other sexually transmitted infections, especially urethral or urine NAAT for CT or gonorrhea (GC), rectal and pharyngeal GC, syphilis, and HIV,.

Providers should submit serologic and microbiologic specimens to their local public health laboratories for performance of these recommended tests. The CDC is requesting that any positive tissue culture isolates or NAAT specimens from suspected cases be forwarded to the CDC's Chlamydia Laboratory for genotyping by nested polymerase chain reaction (PCR) and restriction fragment-length polymorphism (RFLP).

If local public health laboratories do not have the resources or expertise to do MIF or CF serologic testing or CT tissue culture or CT NAAT on non-FDA approved sites such as rectum, at this time the state lab is recommending that specimens be sent directly to the University of California Chlamydia Laboratory since it is the only lab currently running both the most specific MIF test and Clinical Laboratory Improvement Ammendments (CLIA)-approved rectal NAAT testing. Serum for MIF and swab specimens for CT NAAT can be forwarded to:

University of California Chlamydia Laboratory
Box 0842, Building 30, Room 416, 1001 Potrero Avenue
University of California, San Francisco
San Francisco, CA 94143
Phone: (415) 476-2370
FAX: (415) 821-8945

Swab specimens may be collected using a standard kit for DNA hybridization (Gen-Probe®) or DNA amplification (BDProbeTec™, Gen-Probe® APTIMA®, Roche Amplicor™) test, using the swab and associated medium supplied with the kit. If these test kits are not available, collect specimen using a dry sterile swab and place it into a transport tube that does not contain fluid or jelled medium.

Because the CDC is requesting immediate reporting of suspected cases, we are requesting that local health departments immediately report any cases by phone to the

state STD Surveillance and Data Management Unit at 916-552-9812 (Denise Gilson's line) so we can report to the CDC in a timely fashion. Until we have a better understanding of the magnitude of the problem, we are requesting that all case report forms be faxed to the state STD Surveillance and Data Management Unit confidential and secure fax line at 916-552-8974 within 24 hours after the form is completed. The form should be completed as soon as possible after a suspect case is detected.

Further updates, including clinical tools for local providers will be available in the next few weeks, and we will keep you posted on any significant new developments. Please feel free to contact Dr. Chris Hall at (510) 286-6006 or chall@dhs.ca.gov if you have any questions or concerns.

Appropriate Use of Bicillin

As I notified you earlier this year, a clinic in Los Angeles serving the gay community was discovered to have inadvertently used Bicillin C-R instead of Bicillin L-A for treating syphilis. As a result, King Pharmaceuticals have added new warning labels emphasizing correct use.

Bicillin L-A is the only currently approved penicillin G benzathine product indicated for the treatment of syphilis, and Bicillin C-R should not be administered in place of Bicillin L-A. Administration of Bicillin C-R instead of Bicillin L-A in the treatment of syphilis may result in inadequate treatment.

STD clinics and pharmacies should review their tracking systems for ordering and delivering penicillin treatment for syphilis, in order to ensure to ensure correct treatment.

More information is also available on the STD/HIV Prevention Training Website at:

http://www.stdhivtraining.org/pdf/bicillin_primer_ptc_6-14-04.pdf

Proposition 63 and Mental Health programs

California voters have approved Proposition 63, which provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults and seniors. The state is required to develop mental health service programs including prevention, early intervention, education, and training programs. Adolescents and young adults are the priority population being addressed. Specific underserved groups including the homeless, the transition youth discharged from hospitals, juvenile justice facilities (Early and Periodic Screening, Diagnosis, and

Treatment (EPSDT) recipients), and the foster care system are of priority concern. Education and training constitute a special funding component of the initiative, as do school-based programs.

The monies are being distributed via a county planning procedure. The county must present its plan to the state for approval and allocation of funds. This may provide opportunities at the local level for integration of STD/HIV prevention activities among high risk adolescents. For more information, please access the following website: http://www.californiateenhealth.org/AMHPN_overview_November.asp.
In addition, please keep Joyce Lisbin at jlisbin@dhs.ca.gov informed as to any successful local partnerships or collaborative efforts.

Clinical Infectious Disease article on HSV-2 screening guidelines

Clinical Infectious Diseases will be publishing the California HSV-2 screening guidelines in January, the result of a collaborative effort between the California STD Controllers Association and the STD Control Branch. With Dr. Sarah Guerry as the lead author, this article considers the potential risks and benefits of HSV-2 screening in four groups of asymptomatic people: people at high risk for STDs, HIV-positive people, people whose partners have HSV-2, and pregnant women. The authors found that the first three groups are likely to benefit from screening for HSV-2. Infected individuals could be counseled regarding condom use and advised about changing their behavior to reduce the risk of acquiring HIV or transmitting genital herpes.

However, the article concluded that pregnant women who are not HIV-infected and whose partners do not have genital herpes should generally not be screened for HSV-2.

Trainings

The annual “Advances in STDs” conference has been scheduled for May 13, 2005 in San Francisco. The title this year is “Women’s Sexual Health and Sexually Transmitted Diseases.” It is a day-long CME conference sponsored by the California STD/HIV Prevention Training Center on advances in the field and will be held at the Westin Hotel in Millbrae near San Francisco International Airport. To register or for more information contact RDL at (916) 443-0218 or Alex@RDLent.com or www.RDLent.com.

Speakers include Hunter Handsfield, Roberta Ness, Dave Martin, Lawrence Stanberry, Jeanne Marrazzo, and Sevgi Aral on current advances in the intersecting fields of women’s sexual health and STDs, including vaccines for HSV and HPV, new etiologies of cervicitis, new diagnostic tests for cervicitis and vaginitis, developments in pelvic inflammatory disease (PID) management, new developments in the understanding of

risks for STD and HIV associated with women's sexual health and behavior, and expedited partner therapy.

NEW RESOURCES

STD Curriculum

The new curriculum for 7th-12th grades, "Making the Connection Between HIV and STDs," is now available. The order form may be found at: http://www.stdhivtraining.org/pdf/STD_Lesson_Plan_1st_Edition_2004_September.pdf

2003 STD Surveillance Slides

2003 STD Surveillance PowerPoint Slides and new quarterly trend slides are now available on the web at: http://www.dhs.ca.gov/ps/dcdc/STD/datatables.htm.

Please feel free to contact me if you have any further questions at (510) 286-6600. Thank you for all your work and support this year. My best wishes for a happy, healthy holiday season.

Sincerely,

Gail Bolan MD

Gail Bolan, MD
Chief, STD Control Branch

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