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Impact of Closure of a Sexually Transmitted Disease Clinic on Public Health Surveillance of Sexually Transmitted Diseases — Washington, D.C., 1995

In April 1995, a public sexually transmitted disease (STD) clinic in the northwest (NW) ward of the District of Columbia closed, leaving one public STD clinic in the southeast (SE) ward to provide public STD services for the entire city. This report summarizes an investigation by CDC following a request from the District of Columbia Department of Health's STD program to evaluate the impact of the NW STD clinic closure on STD case reports. The findings of this investigation indicate that the clinic closure resulted in a marked decrease in reported syphilis in the NW ward, and suggest that NW ward residents with syphilis and their partners may not have received proper diagnostic testing, therapy, and counseling.

To determine the number and characteristics of patients seen at the STD clinics, the health department's STD clinic reports from May 1, 1994, to April 30, 1996 (the 12 months before and the 12 months after the clinic closed) were reviewed. To assess ward- and clinic-specific trends in case reporting, syphilis and gonorrhea case reports in the health department's STD surveillance database were analyzed. For this analysis, data for the year before and the year after the clinic closed were available for primary and secondary (P&S) syphilis cases, and data for 4 months before and 4 months after the clinic closed were available for gonorrhea cases.

Compared with the 12-month period before the NW STD clinic closed, during the 12-month period after the clinic closed the overall number of patient visits at the health department's STD clinics decreased 37%, from 20,155 to 12,759. The reported cases of P&S syphilis decreased 23%, from 143 cases before the clinic closure to 110 cases after the closure. Among those residing in the NW ward, the number of

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reported cases of P&S syphilis decreased 57%, from 44 cases to 19 cases. However, reported cases among persons residing in the SE ward increased 10% during the same period, from 52 cases to 57 cases. The number of reported cases among women residing in the NW ward did not change, whereas reported cases among women residing in the SE ward increased by 41%, from 22 to 31 (Figure 1). However, among men residing in the NW ward, the number of reported cases decreased 78% (from 32 to seven), and reported cases from men residing in the SE ward decreased 13% (from 30 to 26).

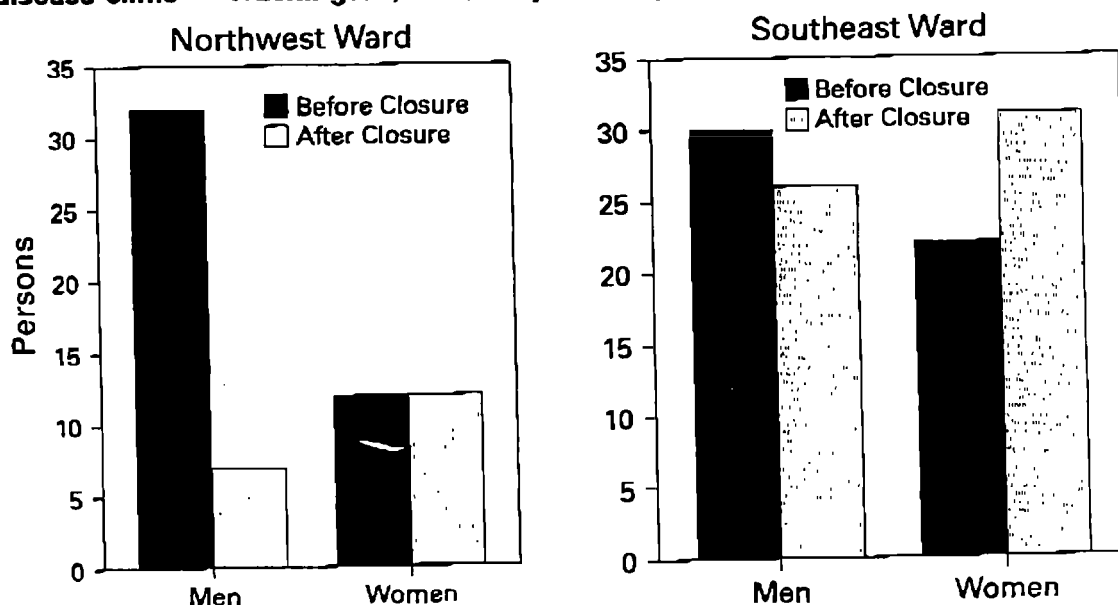
Cases of reported gonorrhea in the District of Columbia decreased 26%, from 6935 cases before the clinic closure to 5166 cases after the closure. The decline in reported gonorrhea cases was seen in all wards.

The numbers of P&S syphilis cases reported for NW residents at the SE STD clinic did not change substantially following the NW STD clinic closure. However, the number of gonorrhea cases reported among NW residents increased at the SE STD clinic from 22 cases to 153 cases.

Reported by: M Levy, MD, J Heath, District of Columbia Dept of Health. Epidemiology and Surveillance Br, Div of Sexually Transmitted Disease Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: Although in the United States syphilis has declined to historically low levels (1), it remains a problem in the District of Columbia. In 1996, the city's syphilis rate was 13th highest for U.S. cities of >200,000 population (2). Data from this investigation suggest that closing the NW STD clinic resulted in unreported syphilis cases. Reporting of syphilis cases is essential if health departments are to ensure that patients and their sex partners are treated and counseled properly, that trends in disease are monitored effectively, and that outbreaks are identified and addressed promptly.

FIGURE 1. Number of persons with reported primary and secondary syphilis, by sex and ward of residence before and after closure of the northwest sexually transmitted disease clinic — Washington, D.C., May 1994–April 1996*



*The 12 months before and the 12 months after closure of the northwest clinic.

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The substantial increase in syphilis among women residing in the SE ward following the clinic closure suggests that a simultaneous increase in the NW ward might not have been detected. Cases in the NW ward may have been missed because of limited access to STD care after the NW STD clinic closure. The number of cases reported among women residing in the NW ward did not decrease as it did for men, possibly because a higher proportion of women than men are tested for syphilis in health-care settings other than STD clinics (e.g., family planning and antenatal care).

The elimination of STD care can result in substantial decreases in STD clinic visits, laboratory testing, and chlamydia and gonorrhea case reports (3). In the District of Columbia, gonorrhea case reports declined, but decreases in all wards were similar. Differences between the specific behaviors of syphilis patients and gonorrhea patients may help to explain the differential impact on reporting. Syphilis patients are more likely than gonorrhea patients to have a greater number of unnamed sex partners and to engage in illicit-drug use and exchange of sex for drugs or money (4). Syphilis patients and their partners may have particular difficulty accessing the health-care system. The signs and symptoms of early syphilis in men often are transient and painless compared with the often persistent urethral discharge and dysuria of gonorrhea; thus, persons with syphilis may not seek health care as readily as persons with gonorrhea. The loss of a public STD clinic may have had a greater impact on the likelihood of identifying, locating, and treating syphilis patients than gonorrhea patients.

The findings in this report are subject to at least two limitations. First, patients who would have been served by the NW STD clinic may have sought STD services from other health-care facilities; however, if such cases were not reported to the health department their sex partners probably did not receive adequate follow-up. Second, although the clinic closure appears to be the most likely explanation for the sharp decline in reporting of syphilis cases among NW residents, other unmeasured factors might have affected the syphilis and gonorrhea rates in the NW ward and elsewhere in the city.

When considering closing any public facility providing health-care services, health departments should evaluate the potential impact on populations with high rates of disease. Specifically, they should assess the extent to which these patients can access the remaining health-care facilities and the capacity of these facilities to handle an increase in patient volume. In settings such as the District of Columbia, measures to increase syphilis case finding should be implemented by expanding routine syphilis serologic screening, strengthening partner notification activities, and improving patient education.

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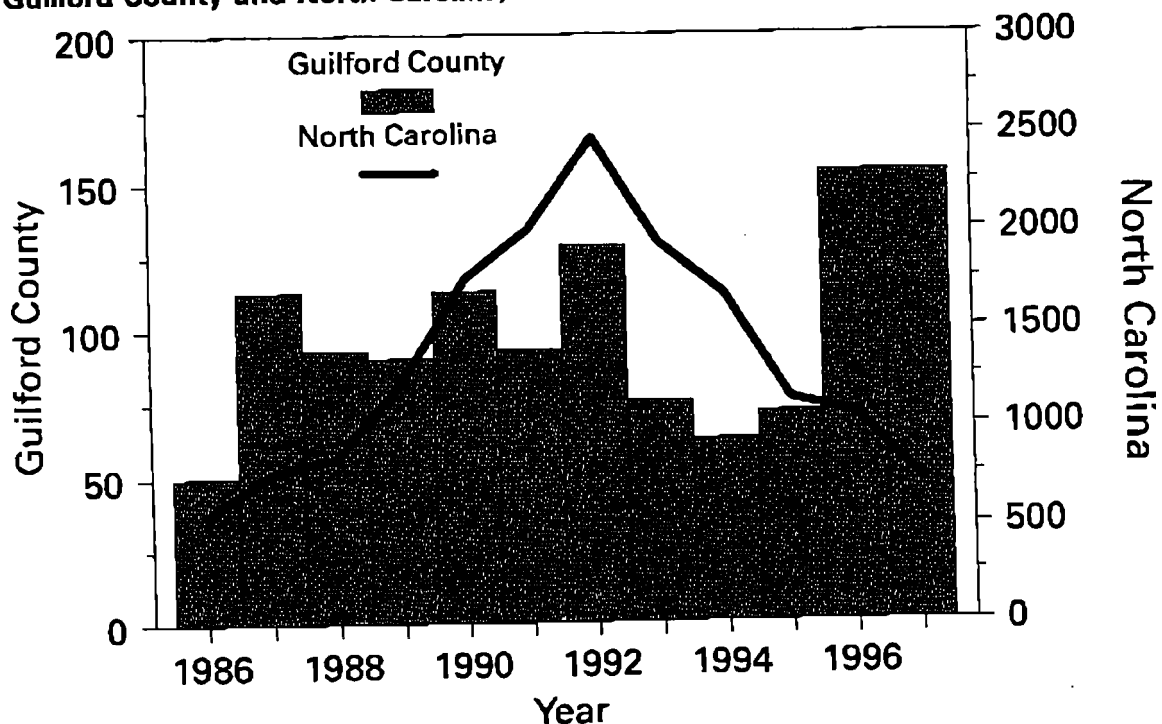
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Outbreak of Primary and Secondary Syphilis — Guilford County, North Carolina, 1996–1997

In 1996 and 1997, 153 cases of primary and secondary (P&S) syphilis were reported each year in Guilford County, North Carolina, a 147% increase from the 62 cases reported in 1994 (Figure 1). The incidence of P&S syphilis in Guilford County during 1996–1997 was 40.5 cases per 100,000 persons, substantially higher than the national health objective for 2000 of four cases per 100,000 (objective 19.3) (1). In comparison, the number of P&S syphilis cases in North Carolina declined 57% from 1994 to 1997 (Figure 1), to a rate of 10.9 per 100,000 in 1997. This report summarizes the results of an investigation conducted by the Guilford County Health Department (GCHD), the North Carolina Division of Epidemiology, and CDC, which suggest this ongoing outbreak has been associated with missed opportunities for syphilis screening and treatment in high-risk settings, increased exchange of sex for money or drugs, and substantial rates of coinfection with syphilis and human immunodeficiency virus (HIV) among those tested.

To assess factors associated with the epidemic, interviews were conducted with P&S syphilis patients, state and local health department staff members, clinicians, and community residents. Demographic data for all residents of Guilford County with reported cases of syphilis from January 1993 (when the present data registry system was initiated) through August 1997 were analyzed to assess trends in factors that might influence syphilis rates (e.g., access to medical care and adequacy of screening and treatment). Also reviewed were the contact index (the number of sex partners for whom information was sufficient to initiate efforts to locate the person divided by the

FIGURE 1. Number of cases of primary and secondary syphilis, by year of report — Guilford County and North Carolina, 1986–1997



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number of persons with syphilis interviewed) and the treatment index (the number of persons treated as a result of partner notification divided by the number of persons interviewed). The roles of illicit-drug use and sex worker activity during the epidemic were assessed. HIV screening and prevalence data were used to assess the extent of HIV coinfection among P&S syphilis patients. Syphilis registry data were used to compare risk factors among P&S syphilis patients reported during the pre-epidemic period (January 1993–December 1995) with P&S syphilis patients reported during the epidemic period (January 1996–August 1997). Screening and prevalence data from the local jails were reviewed (2–6).

Seventy-three percent of Guilford County residents reside in two major cities: Greensboro (1990 population: 192,000) and High Point (1990 population: 74,000). Most (96%) reported P&S syphilis patients in Guilford County reside in these two cities. Of patients in Guilford County who had infectious syphilis from January 1996 through August 1997, 55% were men. The mean age of men with P&S syphilis was 34.5 years in 1993 and 37.2 years during January–August 1997 ($p=0.2$). The mean age of women with P&S syphilis increased significantly from 1993 (27.8 years) through August 1997 (33.3 years) ($p=0.01$).

Patients during the epidemic period were more likely to have used illicit drugs at some time since 1978 (odds ratio [OR]=1.9; 95% confidence interval [CI]=1.1–3.3) and to have exchanged sex for drugs or money during the preceding year (OR=2.1; 95% CI=1.4–3.3) and were less likely to have been tested for HIV (18.6%) than patients before the epidemic period (27.8%; OR=0.6; 95% CI=0.4–0.9). Of P&S syphilis patients tested for HIV infection before and during the epidemic, 16% and 13%, respectively, were HIV infected. On the basis of local police records, prostitution arrests did not increase during 1993–1996, but crack cocaine-related arrests increased 69%.

Public sexually transmitted diseases clinical care appeared to meet the needs of persons seeking care during the epidemic in Greensboro. The contact index was 2.0 in 1993 and 1.7 in 1996, indicating fewer sex partners named per patient interviewed in 1996. However, the treatment index was 0.9 in 1993 and 1.0 in 1996, indicating more patients and contacts were treated for syphilis or preventively treated in 1996.

At the Guilford County jail, full health assessments were offered after 10–14 days of detainment. However, because of a rapid turnover and a high refusal rate, most detainees were not screened. In 1996, 9.6% of those detained in the jail system were screened for syphilis and <1% were screened for HIV infection; 7.5% of syphilis tests and 3.3% of HIV tests were positive. During January–August 1997, 8.0% of detained inmates had a history, physical examination, and syphilis serology, of whom 13.3% had reactive syphilis serologic tests.

To control the increase in syphilis cases in Guilford County, the North Carolina HIV/STD Prevention and Care Section and GCHD, in collaboration with local community organizations, conducted a community intervention effort from July through September 1997. This intervention combined sex partner notification strategies, community outreach, and extended local clinical services to find and treat more patients with P&S syphilis and to educate the community about syphilis. Other prevention measures included alerting the local medical community; obtaining help from community-based organizations in identifying locations where at-risk persons are commonly found and increasing education, outreach, and screening at these locations; and increasing screening and treatment for syphilis at local settings where per-

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sons at high risk may have been encountered (e.g., jails). Based on reported cases of P&S syphilis in Guilford County through August 1998, P&S syphilis is expected to decrease 38% in 1998 compared with 1997.

Reported by: H Gabel, MD, Guilford County Health Dept, Greensboro; E Foust, MPH, D Ogburn, N Engel, J Owen-O'Dowd, A Howerton-Privott, North Carolina HIV/STD Prevention and Care Section, North Carolina Dept of Health and Human Svcs; Greensboro Police Dept. Div of Sexually Transmitted Disease Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: This investigation identified epidemiologic factors frequently associated with syphilis outbreaks in other urban areas of the United States: increased illicit-drug use and exchange of money or drugs for sex. This investigation also identified missed opportunities for rapid syphilis screening and treatment at the local jails. Previous studies have identified emergency departments (EDs) and jails as sites of high syphilis prevalence during epidemics (2–6). Many arrested persons lack medical insurance or have used hospital EDs at their last medical visit (2). Therefore, jails and EDs are potentially high-impact settings for rapid screening and treatment of patients at high risk for syphilis in areas with endemic or epidemic syphilis (2–6).

Increased cocaine arrests corroborated community perceptions of increased crack cocaine use in Guilford County before the onset of the P&S syphilis epidemic. Also, data on P&S syphilis patients during 1996–1997 document increased exchange of sex for drugs or money and an increase in injecting or other drug use, compared with patients during 1993–1995. The link between crack cocaine and injecting-drug use and high-risk sex behaviors has been reported previously (7).

The sequelae of syphilis are substantial, including facilitation of HIV transmission, congenital syphilis, and advanced syphilis lesions affecting the cardiovascular and central nervous systems. The high frequency of HIV infection among persons tested who also have P&S syphilis underscores the need to make HIV counseling, testing, and prevention a priority for patients with syphilis.

Syphilis elimination is a feasible goal in the United States as syphilis rates continue to decline nationally, but outbreaks of P&S syphilis and persisting endemic foci are major obstacles (8). Outbreaks, such as the one in Guilford County, emphasize the prevention strategies and activities needed to maintain national and local progress toward elimination of syphilis, including innovative public health responses tailored to meet the challenge of shifting community patterns of high-risk behaviors and associated new outbreaks of communicable diseases. In addition, findings from this outbreak suggest that strengthening and maintaining screening in jails may be a useful component of syphilis surveillance and early outbreak detection, even in areas with little or no recognized syphilis transmission.

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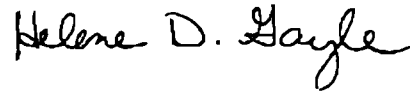
Outbreak of Primary and Secondary Syphilis — Continued

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Dear Colleague--Page Two

Copies of the reports can be downloaded from the CDC Web site at <http://www.cdc.gov/epo/mmwr/mmwr.html>. As always, I hope you find this information useful. If you have any questions or need more information, please call the Office of Communications at (404) 639-8990.

Sincerely,

A handwritten signature in cursive script that reads "Helene D. Gayle".

Helene D. Gayle, M.D., M.P.H.
Director
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
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Atlanta, GA 30333

December 18, 1998

Dear Colleague:

I would like to call your attention to the attached articles, "Impact of a Sexually Transmitted Disease Clinic Closure on Public Health Surveillance of Sexually Transmitted Diseases, Washington, D.C." and "Outbreak of Primary and Secondary Syphilis - Guilford County, North Carolina, 1996-1997," published in today's *Morbidity and Mortality Weekly Report (MMWR)*.

The first article, "Impact of a Sexually Transmitted Disease Clinic Closure on Public Health Surveillance of Sexually Transmitted Diseases, Washington, D.C.," summarizes an investigation to evaluate the impact of the District of Columbia Department of Health's Northwest (NW) Sexually Transmitted Disease (STD) clinic closure on reported STD morbidity, leaving only one clinic to service the entire city. The data suggest that:

- The closing of the clinic in April, 1995 resulted in cases of syphilis being untreated and unreported.
- Patients and their partners who resided in the NW clinic area may not have received proper diagnosis, therapy, and counseling.

The *MMWR* article concludes that when health departments consider closing any public facility providing health services, the potential impact on populations with high rates of disease must be evaluated in advance. Careful consideration should be given to alternatives for accessing services. Specifically, the authors stress that health departments should assess the extent to which these patients can access the remaining health care facilities and the capacity of these facilities to handle an increase in patient volume.

The second article, "Outbreak of Primary and Secondary Syphilis - Guilford County, North Carolina, 1996-1997," summarizes the results of an investigation conducted by the Guilford County Health Department and CDC.

The report indicates that ongoing syphilis outbreaks have been associated with missed opportunities for syphilis screening and treatment in high-risk settings, increased exchange of sex for money or drugs, and substantial rates of infection with syphilis and HIV among those tested.

Outbreaks, such as the one in Guilford County, clarify that prevention strategies and activities - particularly in locations such as jails - are needed to maintain national and local progress toward elimination of syphilis. Public health responses must be tailored to meet the challenge of shifting community patterns of high-risk behaviors and associated new outbreaks of communicable diseases.

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*Recommendations
and
Reports*

MORBIDITY AND MORTALITY WEEKLY REPORT

1998 Guidelines for Treatment of Sexually Transmitted Diseases

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333



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1998 Guidelines for Treatment of
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