

# THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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## New Tools for Diagnosing Primary and Secondary Syphilis

While more than three years have passed since the initiating syphilis outbreak was identified in Los Angeles County, increasing numbers of cases are still being identified; 149 cases of primary and secondary syphilis have been reported in the first half of 2003,<sup>1</sup> 16% more cases than was reported during the same period in 2002 (n=125).

Although curable, syphilis is a serious, complex disease caused by the bacteria *Treponema pallidum*. This organism is commonly transmitted by contact with infected lesions (sores, rashes, etc.) during sexual contact. Someone may also acquire syphilis by touching the skin lesions that occur during secondary syphilis, although this is rare. Syphilis may also be transmitted from mother to child during pregnancy.

Continued on page 6

## RESUMPTION OF ROUTINE IMMUNIZATION SCHEDULE FOR PNEUMOCOCCAL CONJUGATE VACCINE

The Centers for Disease Control and Prevention (CDC) and the California Department of Health Services Immunization Branch have determined that the nationwide shortage of pneumococcal conjugate vaccine (PCV-7) has ended. The production and distribution of this vaccine are now sufficient to allow a return to the routine schedule for vaccine administration (Table 1, page 9).

### The PCV-7 vaccine is recommended for:

- All children under 24 months of age.
- Children 24 months through 59 months who have an increased risk for invasive pneumococcal disease (i.e., children with sickle cell anemia, asplenia, chronic illness, a cerebrospinal fluid leak, a cochlear implant, or an immunocompromising condition).
- All other children 24 months through 59 months should be considered for vaccination – with priority given to children 24 months through 35 months, American Indian children, Alaskan Native children, African American children, and children attending group child-care.

Health care providers are advised to resume the routine immunization schedule for this vaccine **immediately** and to provide catch-up immunization for children who were not completely immunized as a result of the shortage. Children under 18 months of age can receive catch-up immunizations during regularly scheduled health visits but older children who are not scheduled to be seen before their 2nd birthday should receive special notification to return sooner. A catch-up immunization schedule for PCV-7 details the recommended regimens for late starts or lapses in administration (Table 2, page 10).

Continued on page 8

### New Tuberculosis Treatment Guidelines Next Issue

New specifications for the treatment of TB will be featured in the September issue of **The Public's Health**. The guide is currently available at: <http://ajrcm.atsjournals.org/cgi/reprint/167/4/603.pdf>

For questions, please contact the Tuberculosis Control Program at (213) 744-6160.

# THE PUBLIC'S HEALTH

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**Public Health**

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# New User-Friendly STD Confidential Morbidity Report

To facilitate the reporting of new cases of sexually transmitted diseases (STD), the Los Angeles County STD Program has revised the STD Confidential Morbidity Report (CMR) for improved design and readability. The new two-page form contains three sections requesting information about: the provider, patient, and diagnosis and treatment.

Among the recent changes, the provider section now includes space for a clinic stamp for easier completion. In the diagnosis and treatment section, specimen collection date and treatment date are needed for chlamydia and gonorrhea cases. For cases of congenital syphilis, separate CMRs are needed for both the infant and the mother. Finally, instructions for form submission and how to obtain additional information about STD case definitions and HIV reporting have been added. These changes were developed through usability testing involving clinic staff at several county public health centers.

As mandated by state law (California Administrative Code, Title 17, Public Health, Section 2500), healthcare providers must report newly identified cases of STDs (including chlamydia, gonorrhea, chancroid, non-gonococcal/non-chlamydial urethritis, and pelvic inflammatory disease) within seven calendar days, with the exception of syphilis, which must be reported within one working day. Timely and accurate reporting of STDs is crucial to disease control efforts. This requirement does not contradict the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule which allows covered entities to disclose protected health information to public health authorities when required by federal, tribal, state, or local laws [45 CFR 164.512(a)].

***For more information about STD reporting or questions about HIPAA rules for reporting STD cases contact the STD Program at (213) 744-3070. ☎***



LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE  
CONFIDENTIAL MORBIDITY REPORT



DATE OF REPORT   -   -   REPORT  New REPORT   
STATUS:  Update BY NAME:

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DIAGNOSING MEDICAL PRACTITIONER (LAST NAME & FIRST NAME)

FACILITY/CLINIC NAME

STREET ADDRESS

CITY/TOWN

STATE  AREA CODE  OFFICE TEL  -

ZIP CODE  AREA CODE  OFFICE FAX  -

TITLE ABBREVIATION

SUITE/UNIT NO.

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PATIENT'S LAST NAME  FIRST NAME  MI

MEDICAL RECORD NUMBER  SOCIAL SECURITY NUMBER  -  -  OCCUPATION

PATIENT'S STREET ADDRESS

CITY/TOWN  STATE  ZIP CODE

AREA CODE  DAY TEL  -  AREA CODE  EVENING TEL  -

AGE:  BIRTH DATE:   -      PREGNANT:  Yes →  Unknown  No If yes, LMP:

**GENDER:**  
 Male  
 Female  
 Transgender (M to F)  
 Transgender (F to M)

**MARITAL STATUS:**  
 Single  
 Married  
 Domestic Partner  
 Separated  
 Divorced  
 Widowed  
 Living with Partner

**RACE: (X all that apply):**  
 White  
 Black or African American  
 Native American or Alaska Native  
 Asian or Asian American  
 Native Hawaiian or Pacific Islander  
 Unknown  
 Other:

**ETHNICITY: (X only one):**  
 Hispanic or Latino  
 Non Hispanic/ Non-Latino

**GENDER(S) of SEX PARTNERS: (X all that apply):**  
 Male  
 Female  
 Transgender (M to F)  
 Transgender (F to M)  
 Unknown  
 Refused

**For HIV REPORTING:**  
Call (213) 351-8516 or visit  
[www.lapublichealth.org/hiv](http://www.lapublichealth.org/hiv)

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**CHLAMYDIA**

**DIAGNOSIS: (X one):**  
 Asymptomatic  
 Symptomatic - uncomplicated  
 Pelvic Inflammatory Disease  
 Ophthalmia/Conjunctivitis  
 Other:

**SITE: (X all that apply):**  
 Cervix  
 Urethra  
 Rectum  
 Nasopharynx  
 Conjunctiva  
 Other:

**Specimen:**  Urine   Other

**Collection Date:**

**Treatment Date:**        Not treated

**Medication & Dose:**

**Partner Information:** Number partners  (last 60 days) Number treated  Number Partner Delivered Therapy:

**GONORRHEA**

**DIAGNOSIS: (X one):**  
 Asymptomatic  
 Symptomatic - uncomplicated  
 Pelvic Inflammatory Disease  
 Ophthalmia/Conjunctivitis  
 Disseminated  
 Other:

**SITE: (X all that apply):**  
 Cervix  
 Urethra  
 Rectum  
 Nasopharynx  
 Conjunctiva  
 Other:

**Specimen:**  Urine   Blood   Other

**Collection Date:**

**Treatment Date:**        Not treated

**Medication & Dose:**

**Partner Information:** Number partners  (last 60 days) Number treated

**SYPHILIS, CONGENITAL SYPHILIS, OTHER REPORTABLE STDs AND REPORTING INFORMATION ON BACK PAGE.**



PATIENT'S LAST NAME (COMPLETE SECTIONS 1 & 2 FIRST)

FIRST NAME

MI

Grid for patient last name

Grid for patient first name and middle initial

**SYPHILIS**

Primary Syphilis: Onset Date (MM-DD-YY), Lesion Sites (Genital, Perirectal, Oral, Other, Vagina, Rectum)

Secondary Syphilis: Onset Date (MM-DD-YY), Symptoms (Palmar/Plantar Rash, Gen. Body Rash, Alopecia, Other)

Latency: Early Latent (<=1 Year), Late Latent (>1 Year), Latent, Unknown Duration, Late Syphilis, Neurosyphilis (with description box)

Laboratory Test Date (MM-DD-YY), Diagnosis Date (MM-DD-YY), Partner Information (Number elicited, Number treated)

Titer: RPR or VDRL, TP-PA or FTA-ABS or Other, CSF - VDRL; Patient Treated (Yes/No), Date(s) Treated, Medication / Dose

**CONGENITAL SYPHILIS (SEPARATE CMR SHOULD BE SUBMITTED FOR MOTHER)**

**INFANT INFORMATION**

**MATERNAL INFORMATION**

Birth Date (MM-DD-YY), Gestational Age (wks)

Mother's Last Name

Live Birth, Still Birth

Mother's First Name

Symptoms: Yes/No, Describe

Mother's Medical Record Number

Serum: RPR (Reactive, Non-reactive, Not Done), Titer

Mother's Birth Date, Mother's Serology at Delivery (Lab Test Date)

Titer 4x > mothers?: Yes/No

Stage of Syphilis at Diagnosis (Primary, Secondary, Early Latent, Late Latent, Latent, Unknown Duration, Late Syphilis), RPR or VDRL, Titer, TP-PA or FTA-ABS or Other, Reactive, Lumbar Puncture Done

CSF: VDRL, WBC >5/mm<sup>3</sup>, Protein >50mg/dl

Date(s) Treated, Medication / Dose

Long Bone X-rays: Positive/Negative

Date(s) Treated, Medication / Dose

Infant Treated: Yes/No

Date(s) Treated, Medication / Dose

(If yes, attach record of treatment dates and doses.)

**OTHER REPORTABLE STDs**

Table with columns: Diagnosis, Treated, Date Treated, Medication / Dose. Rows for Pelvic Inflammatory Disease, Non-Gonococcal/Non-Chlamydial Urethritis, Chancroid

3 cont.

DIAGNOSIS & TREATMENT

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SEND

FAX BOTH SIDES TO: (213) 749-9602

OR MAIL TO: STD PROGRAM, 2615 S. GRAND AVENUE, RM. 450, LOS ANGELES, CA 90007

5

INFO

TO REQUEST CMR FORMS & ENVELOPES: Call (213) 741-8000 or DOWNLOAD at: www.lapublichealth.org/std/providers.htm

FOR CASE DEFINITIONS & REPORTING QUESTIONS: Call (213) 744-3070 or visit www.lapublichealth.org/std/providers.htm

FOR HIV REPORTING: Call (213) 351-8516 or visit www.lapublichealth.org/hiv

# The Downtown Chlamydia Mobilization Project:

## Improving the Health of Low Wage, Immigrant Garment Workers

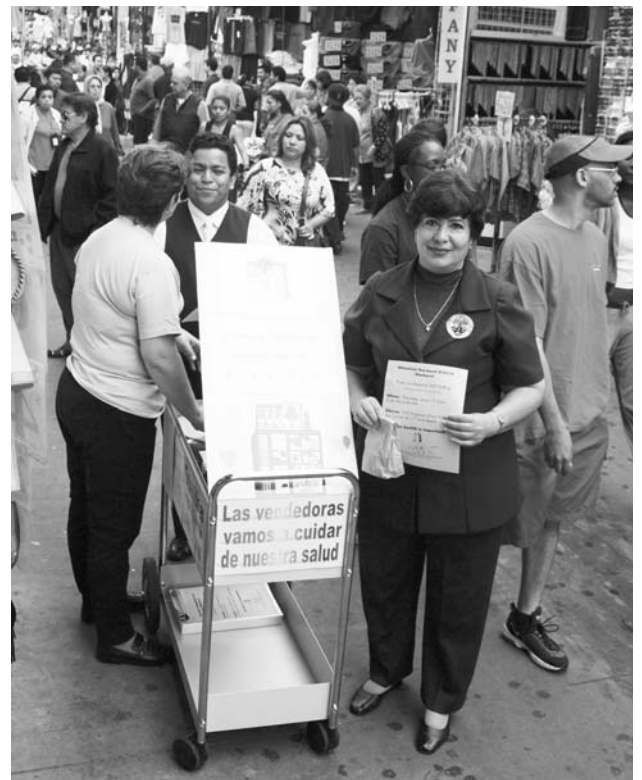
With an estimated 150,000 garment workers in Los Angeles County, the majority are located in the garment district, a 50-square block area located just east of central downtown. Many of these garment workers are Latina women who have recently immigrated to the United States. Many of them are low-income and lack healthcare. A formative research survey conducted in 2002 by the STD Program revealed that barriers to healthcare access include extremely low wages and long days at work. Another preliminary survey in 2001 showed that 80% of respondents were not aware of chlamydia, despite the fact that Latinas account for about 37% of chlamydia cases among women in the county and disproportionately suffer complications arising from untreated chlamydia, such as pelvic inflammatory disease and ectopic pregnancy.

The Downtown Chlamydia Mobilization Project, funded by the Centers for Disease Control and Prevention, was developed in order to reach out to members of this unique population and to increase their knowledge of STDs, teach prevention, and increase access to health services. Work on the project began in early 2002, with the STD Program meeting with representatives from the Garment Worker Center, Los Angeles Trade Technical College, Norwood Street Elementary School Healthy Start, Health Access, Maternal and Child Health Access, Planned Parenthood, and the health department's Binational Border Health Program. Today, STD Program staff and volunteers have started hitting the busy streets of the garment district in order to spread their messages. Using colorfully decorated office carts containing educational and prevention materials, they engage the garment workers as well as merchants and shoppers in both English and Spanish, providing health information, condoms, and referrals to local health clinics. In addition to this one-on-one interaction, the project will work with groups of women through training sessions, a media campaign, and the development of a Women's Sexual Health Coalition.

*Using colorfully decorated office carts containing educational and prevention materials, they engage the garment workers as well as merchants and shoppers in both English and Spanish, providing health information, condoms, and referrals to local health clinics.*

Because garment workers are usually isolated due to the nature of their work, the STD Program hopes that these multi-level activities will empower the women to be able to create positive changes in their own lives and communities. Based on the progress to date, the project has received an extension of the initial award for another year.

For more information about this project, contact Elaine Waldman, STD Program Community Outreach Services Unit Project Director at (213) 744-3084. [K](#)



## Syphilis Algorithms: (from page 1)

Because the initial sore that develops during primary syphilis is painless, many people may not notice the symptom or know they have syphilis. If the sore is inside the body (penis, rectum, vagina, or mouth), it will be harder to detect. A few weeks after the sore disappears, a rash may appear on the body, hands, and/or feet; this stage is called secondary syphilis. Other symptoms may include mild fever, sore throat, or hair loss. A year after infection, symptoms usually go away by themselves and the person is no longer infectious to sex partners. However, the disease will remain inside the body if left untreated and can cause serious complications years later.

Given the complicated nature of syphilis, the California STD/HIV Prevention Training Center (CA PTC)<sup>2</sup> has created some diagnostic and treatment algorithms to help healthcare providers evaluate their patients for primary and secondary syphilis.

Much of the information is concise and easy to use. In the evaluation process, the diagnostic and treatment algorithms highlight the importance of taking the patient's sexual history and conducting a risk assessment that covers the following factors: gender of partners, number of partners, types of sexual exposure, recent STDs and HIV serostatus, substance abuse, and condom use. The algorithms also provide flow charts that explain the diagnostic work-up, as well as treatment and follow-up guidelines for both primary and secondary syphilis. Other helpful tools are photos of clinical presentations of syphilis and listings of the differential diagnosis for both primary and secondary syphilis. A differential diagnosis of the sore of primary syphilis includes: herpes, chancroid, primary HIV ulcers, trauma, and many non-STD causes of genital ulcers. For secondary syphilis, a differential diagnosis of the rash includes: pityriasis rosea, psoriasis, erythema multiforme, tinea versicolor, scabies, drug reaction (e.g. from HAART medications), and primary HIV infection.

***The algorithms also provide flow charts that explain the diagnostic work-up, as well as treatment and follow-up guidelines for both primary and secondary syphilis.***

These algorithms have been provided in this issue and are also available at: [www.stdhivtraining.org/cfm/resources.cfm#SyphilisTools](http://www.stdhivtraining.org/cfm/resources.cfm#SyphilisTools). Print copies of the 11 X 17 poster can also be obtained by calling Pitney Bowes Management Services at (408) 590-6168. ☎

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1. Sexually Transmitted Disease Program, Los Angeles County Department of Health Services. Early Syphilis Surveillance Summary, July 2003;1-16.

2. CA PTC is funded by the CDC and is a joint project of the California Department of Health Services, Sexually Transmitted Disease Control Branch, the University of California, Berkeley, School of Public Health, and the University of California San Francisco, School of Medicine.

# Adolescent Hepatitis B Immunizations

## Prevent the Transmission of Hepatitis B in Kids 15-18 Years Old

Many adolescents between the ages of 15-18 years old missed out on hepatitis B immunizations as infants and were again exempt from California's state-mandated hepatitis B immunizations for school entry. Thus despite hepatitis B immunization coverage estimates of over 60% among middle school kids, many 15-18 year olds remain unvaccinated or have not sufficiently completed the hepatitis B immunization series which leaves them unprotected and vulnerable to acute and/or chronic infection.

Doctors and health care workers can be instrumental in preventing acute and/or chronic hepatitis B transmission in 15-18 year olds by:

- Routinely reviewing and maintaining the immunization records of adolescent patients between the ages of 15-18 years.
- If hepatitis B immunizations have not been started, begin the three-dose series. The usual schedule for adolescents is two doses (0.5 ml) separated by no less than 4 weeks, and a third dose 4-6 months after the second dose. If the accelerated schedule is needed, the minimum interval between the first two doses is 4 weeks, and the minimum interval between the second and third doses is 8 weeks. However, the first and third doses **must** be separated by 4 months.
- 11-15 year olds may receive the two 10 mcg doses of RecombivaxHB separated by 4-6 months.
- If a patient started but did not complete the hepatitis B three-dose series, **DO NOT START THE SERIES AGAIN**. Instead, resume vaccination until the required three doses are completed.
- Recall/Remind patients to return to the clinic to finish the recommended doses in order to satisfy the immunization series.

*Many 15-18 year olds remain unvaccinated or have not sufficiently completed the hepatitis B immunization series which leaves them unprotected and vulnerable to acute and/or chronic infection.*

- Enroll as a Vaccines for Children Provider (VFC), a federally-funded, state-operated vaccine supply program that helps offset the costs of the vaccine to the patient and medical provider.

Careful immunization history of adolescents 15-18 years old can prevent future cases of hepatitis B and other life-threatening liver diseases. Don't miss this opportunity to save lives, be sure to vaccinate your adolescent patients who are 15-18 years old. Additional information about hepatitis B immunizations for adolescents is available in the March/April 2003 issue of The Public's Health at: [www.lapublichealth.org/www-files/ph/ph/TPHMarApr2003.pdf](http://www.lapublichealth.org/www-files/ph/ph/TPHMarApr2003.pdf)

For more information about hepatitis B immunizations, contact Wendy Berger at the Immunization Program at 213-351-7800. ☎

## Pneumococcal Conjugate Vaccine: (from page 1)

### The priority for PCV-7 catch-up immunizations are as follows:

- **Highest priority:** Children under 5 years of age who have a medical condition which puts them at high risk for invasive pneumococcal disease.
- Healthy children under 24 months of age who have received no previous dose of PCV-7.
- Children under 12 months of age who have not received all of the routinely recommended doses.

If you have questions or require additional information regarding the PCV-7 immunization schedule, please contact the Immunization Program at (213) 351-7800. ☎

## Los Angeles County SARS Summary:

# SARS CASE IDENTIFICATION ENDS

Now that several incubation periods have passed without the identification of new SARS cases in areas with community transmission of SARS, the travel criteria for U.S. SARS case identification have ended. With the removal of Taiwan on July 25, no areas remain, and as such, the identification of U.S. SARS cases resulting from travel has concluded. Nonetheless, the CDC will continue to consider cases of pneumonia with unknown etiology on a case-by-case basis. The current and full CDC SARS case definition is available at: [www.cdc.gov/ncidod/sars/casedefinition.htm](http://www.cdc.gov/ncidod/sars/casedefinition.htm)

*For questions regarding case identification, call ACDC at (213) 240-7941*

### Summary of LAC SARS Cases (8-13-03):

CDC guidance permits reclassification of SARS cases if: 1) another diagnosis is made that fully explains the patient's condition; or 2) a convalescent serologic test is negative for SARS-Coronavirus (SARS-CoV) antibodies. Among the 22 potential SARS cases investigated in LA, none has been confirmed as positive for SARS coronavirus infection and more than half (n=12) have been excluded due to negative convalescent serologies. Test information cannot be completed for many of the cases (41%, n=9). Most (n=7) are foreign cases who were identified while visiting in Los Angeles, but have now returned to their home countries. The remaining 2 suspect cases are local residents who refused to submit final specimens. Of these cases without a convalescent result, the acute specimens for most (n=8) were negative, one did not submit acute specimens. ☎

### Los Angeles SARS Case Summary (8-13-03)

	Probable SARS (n=7)	Suspect SARS (n=15)	Total Cases (n=22)
<b>Classification Completed</b>	<b>7</b>	<b>6</b>	<b>13</b>
Other diagnosis	1	0	1
Negative SARS-CoV convalescent Ab	6	6	12
<b>Classification unable to be completed</b>	<b>0</b>	<b>9</b>	<b>9</b>
Foreign resident, final tests unavailable	0	7	7
Testing incomplete, refused	0	2	2
<b>Classification pending final tests</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Confirmed SARS-CoV</b>	<b>0</b>	<b>0</b>	<b>0</b>



**TABLE 1**

**PNEUMOCOCCAL CONJUGATE VACCINE**

**Schedule:**

Recommended schedules for pneumococcal conjugate vaccine vary with the child's age and the presence of underlying conditions. The schedules are given in the table below.

Age at First Dose	Total # of Doses	Schedule
2 - 6 months	4	2, 4, 6 months of age 4 to 8 weeks apart, with a booster at 12-15 months of age <sup>1</sup>
7 -11 months	3	2 doses 4 to 8 weeks apart <sup>2</sup> ; give the third (booster) dose after the first birthday and at least two months after the second dose
12 - 23 months	2	2 doses 6 to 8 weeks apart
24 - 59 months	1-2	2 doses 6 to 8 weeks apart if child is at high risk <sup>3</sup> ; 1 dose for healthy children <sup>4</sup>

<sup>1</sup>The first dose is usually given at 2 months of age, but it can be given as early as 6 weeks of age. The recommended interval between doses is 2 months, however, 4 weeks is the minimal interval. The AAP prefers that these doses be 6-8 weeks apart. The booster dose is given at least 2 months after the third dose.

<sup>2</sup>The AAP prefers that these doses be 6-8 weeks apart.

<sup>3</sup>Children between 24 and 59 months who are at high risk and who should be immunized with 2 doses (6 to 8 weeks apart) are children with:

- Sickle cell anemia
- Functional or anatomic asplenia
- HIV infection or AIDS
- Other immunocompromising conditions due to malignancies, chronic renal insufficiency, nephrotic syndrome, organ transplant, high-dose steroid use, etc.
- Other chronic illnesses, e.g., diabetes, cardiac disease, pulmonary disease (except asthma), CSF leaks, cochlear implant.

<sup>4</sup>The ACIP approves the use of VFC vaccine for all children 24 through 59 months of age, with priority given to vaccination of moderate-risk children including:

- Children between 24-35 months of age
- Children who are Alaskan Natives, American Indians, or African American
- Children who are in group day care (this does not include kindergarten children)

**Dosage, Route and Site of Administration:**

- Dose: 0.5 mL
- Route: Intramuscular (IM)
- Site: Anterolateral thigh in infants and the deltoid in toddlers and young children

**Contraindications to Vaccination:**

- Acute, moderate to severe illness until patient has improved
- History of a serious allergic reaction to a prior dose of pneumococcal conjugate vaccine or to a vaccine component, including diphtheria toxoid

**Adverse Reactions:**

- Injection site redness and/or soreness (10% to 30% of recipients)
- Fever (most fevers are low grade and resolve within one day)
- No serious adverse reactions have been reported.

TABLE 2

**Recommended regimens for pneumococcal conjugate vaccine among children with a late start or lapse in vaccine administration**

Age at examination	Previous pneumococcal conjugate vaccination history	Recommended regimen*
2 – 6 months	0 doses 1 dose 2 doses	3 doses 2 months apart, 4 <sup>th</sup> dose at age 12-15 months 2 doses 2 months apart, 4 <sup>th</sup> dose at 12-15 months 1 dose, 4 <sup>th</sup> dose at 12-15 months
7 – 11 months	0 doses 1 or 2 doses before age 7 months	2 doses 2 months apart, 3 <sup>rd</sup> dose at 12-15 months 1 dose, at 7-11 months, with another dose at 12-15 months ( $\geq 2$ months later)
12 – 23 months	0 doses 1 dose before age 12 months 1 dose at $\geq 12$ months 2 or 3 doses before age 12 months	2 doses $\geq 2$ months apart 2 doses $\geq 2$ months apart 1 dose $\geq 2$ months after the most recent dose 1 dose $\geq 2$ months after the most recent dose
24 – 59 months		
Healthy children†	Any incomplete schedule	Consider 1 dose $\geq 2$ months after the most recent dose
High risk§	< 3 doses 3 doses	1 dose $\geq 2$ months after the most recent dose and another dose $\geq 2$ months later 1 dose $\geq 2$ months after the most recent dose

\* For children vaccinated at age < 1 year, the minimum interval between doses is 4 weeks. Doses administered at  $\geq 12$  months should be at least 8 weeks apart.

† Providers should consider 1 dose for healthy children aged 24-59 months, with priority to children aged 24-35 months, American Indian/Alaska Native, and African American children, and those who attend group child care centers.


§ Children with sickle cell disease, asplenia, human immunodeficiency virus infection, chronic illness, cochlear implant, or immunocompromising condition.

## American Cancer Society and UCLA Seek to Enroll Current and Former Smokers in Lung Screening Study

While diagnosing lung cancer during its early stages substantially improves survival, few cases are identified at this stage. A new technology called spiral computed tomography (spiral CT) may improve the lung tumor detection rate. A national lung screening trial will enroll 50,000 current or former smokers at 30 nationwide sites to assess screening procedures. Participants will receive, free of charge, two scans, either a spiral CT scan or chest x-ray, over two years.

Participant criteria includes:

- current or former smokers ages 55 to 74
- never had lung cancer or any other cancer in the last 5 years (except some forms of skin cancer)
- not currently enrolled in any other cancer screening or prevention trial
- had not had a CT scan of the chest or lungs in the last 18 months

For more information: 1-877-222-NLST or 1-800-ACS-2345 or visit [www.cancer.org](http://www.cancer.org) 



## ANTIBIOTIC RESISTANCE INFORMATION CORNER

### Increasing Fluoroquinolone Resistance in Gonorrhea Isolates in California

Melanie Taylor MD MPH, Jorge Montoya PhD

STD treatment guidelines from the CDC include fluoroquinolones (FQ) as first-line treatment for uncomplicated gonococcal infections. However, in areas, such as Los Angeles, where FQ resistance is prevalent, FQs are not longer recommended. California's gonorrhea treatment guidelines were revised to account for FQ resistance and the recent discontinuation of Cefixime, the only oral cephalosporin listed as first-line treatment in California.

1. Avoid FQs (ciprofloxacin, ofloxacin and levofloxacin) to treat gonorrhea.
2. The antibiotic of choice to treat uncomplicated gonococcal infections of the cervix, urethra, and rectum is Ceftriaxone 125mg intramuscularly in a single dose.
3. Alternative regimens for the treatment of uncomplicated gonococcal infections of the cervix, urethra, and rectum include:
  - a. **Ceftizoxime** 500mg intramuscularly; OR
  - b. **Cefoxitin** 2 grams intramuscularly with Probenecid 1 gram orally; OR
  - c. **Cefotaxime** 500mg intramuscularly; OR
  - d. **Spectinomycin** 2 grams intramuscularly in a single dose; OR
  - e. **Azithromycin** 2 grams orally in a single dose; OR
  - f. **Cefpodoxime** 400mg orally in a single dose; OR
  - g. **Cefuroxime axetil** 1 gram orally in a single dose.
4. The antibiotics of choice to treat gonococcal infections of the pharynx include:
  - a. **Ceftriaxone** 125 mg intramuscularly in a single dose; OR
  - b. **Azithromycin** 2 grams orally in a single dose.
5. For patients with significant anaphylaxis type (IgE mediated) allergies to penicillin, where the use of cephalosporins is a concern, or patients with allergies to cephalosporins:
  - a. **Spectinomycin** 2 grams intramuscularly in a single dose; OR
  - b. **Azithromycin** 2 grams orally in a single dose.

Co-treatment of chlamydia is still recommended in persons diagnosed with gonorrhea unless chlamydia has been ruled out using sensitive test technology or when 2 grams of azithromycin has been used to treat gonorrhea. Treatments for chlamydia include:

1. **Azithromycin** 1 gram orally in a single dose; OR
2. **Doxycycline** 100mg orally twice a day for 7 days.

Source: Gonorrhea Treatment Recommendations in California (revised June 25, 2003) California DHS, STD Control Branch  
[http://www.stdhivtraining.org/pdf/Rx\\_gonorrhea\\_in\\_CA\\_Guidelines.pdf](http://www.stdhivtraining.org/pdf/Rx_gonorrhea_in_CA_Guidelines.pdf) 

# West Nile Virus

With the rapid increase of WNV cases occurring in areas across the U.S., LA residents are reminded that their efforts to reduce mosquito breeding is more important than ever; eliminating sources of stagnant water which foster mosquitoes can help prevent WNV and other mosquito-borne diseases. The public is also encouraged to report dead birds which may identify the presence of WNV (1-877-747-2243).

For recorded information on West Nile Virus call: 800-975-4448 (English, Spanish, Thai, Korean, Mandarin Chinese, Vietnamese)

For questions regarding the reporting of WNV cases call: Acute Communicable Disease Control (213-240-7941)  
or visit: [www.lapublichealth.org/acd/VectorWestNile.htm](http://www.lapublichealth.org/acd/VectorWestNile.htm)

## This Issue . . .

Syphilis Algorithms . . . . .	1
Pneumococcal Conjugate Vaccine Schedule . . . . .	1
STD Confidential Morbidity Report . . . . .	2
Downtown Chlamydia Mobilization Project . . . . .	5
Adolescent Hepatitis B Immunizations . . . . .	7
L.A. County SARS Summary . . . . .	8
Antibiotic Resistance Information Corner . . . . .	11

# THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County



COUNTY OF LOS ANGELES  
DEPARTMENT OF HEALTH SERVICES  
**Public Health**

313 North Figueroa Street, Room 212  
Los Angeles, California 90012

## Selected Reportable Diseases (Cases)<sup>1</sup> - March - April 2003

Disease	THIS PERIOD Mar-April 03	SAME PERIOD LAST YEAR Mar-April 02	YEAR TO DATE		YEAR END TOTALS		
			2003	2002	2002	2001	2000
AIDS <sup>2</sup>	473	276	819	541	1,787	1,354	1,648
Amebiasis	19	21	38	34	109	139	109
Campylobacteriosis	124	127	301	280	1,092	1,141	1,273
Chlamydial Infections	6,249	5,806	11,520	10,298	36,590	31,658	30,642
Encephalitis	9	8	17	17	63	41	49
Gonorrhea	1,202	1,301	2,219	2,374	7,985	7,468	7,212
Hepatitis Type A	63	109	127	196	482	542	839
Hepatitis Type B, Acute	7	6	14	11	27	44	65
Hepatitis Type C, Acute	0	0	0	0	3	1	28
Measles	0	0	0	0	0	8	5
Meningitis, viral/aseptic	104	103	171	193	669	530	491
Meningococcal Infections	7	11	15	25	46	58	53
Mumps	5	13	7	14	16	17	29
Non-gonococcal Urethritis (NGU)	292	237	448	411	1,398	1,343	1,575
Pertussis	37	31	62	55	167	103	102
Rubella	0	0	0	0	0	0	3
Salmonellosis	160	101	306	281	990	1,006	990
Shigellosis	125	62	320	187	922	684	849
Syphilis, primary & secondary	67	57	125	88	362	181	136
Syphilis, early latent (<1 yr.)	46	59	95	101	341	191	194
Tuberculosis	152	141	219	206	1,025	1,046	1,065
Typhoid fever, Acute	4	4	5	6	34	17	21

1. Case totals are provisional and are subject to change following publication.

2. Case totals are interim and may vary following periodic updates of the database.