QUARTERLY MORBIDITY REPORT

William R. Steinhaus, Dutchess County Executive

Michael C. Caldwell, Commissioner of Health

Issue 4 Volume 1

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Our Mission is to protect and promote the health of individuals, families, communities, and the environment.

We are committed to the core functions of public health: Assessment, Assurance, and Policy Development.

We strive to deliver the essential services necessary for people to live healthy lives.

We are increasingly data-driven in our priority setting, applying our resources in ways that optimize prevention and risk reduction.

Resources

Not Just Lyme:
Other Tickborne Diseases
in the Hudson Valley.

A free educational program and dinner designed to provide physicians and other health care providers with the latest information on other tick-borne diseases in the Hudson Valley, including anaplasmosis and babesiosis.

Wednesday, May 20, 2009
5:30-9:30 pm
The Grandview,
176 Rinaldi Boulevard
Poughkeepsie, New York

Please RSVP by May 13, 2009.
Christen Hertzog
By email to:
chertzog@co.dutchess.ny.us

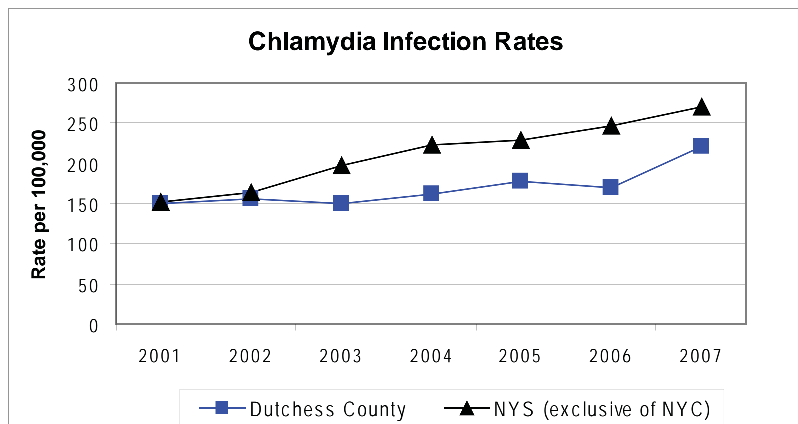
Expedited Partner Delivered Therapy in New York State

MICHAEL C. CALDWELL, MD, MPH, DUTCHESS COUNTY COMMISSIONER OF HEALTH

In January 2009, new legislation went into effect in New York State that will allow Expedited Partner Delivered Therapy (EPT) for sexual contacts of persons diagnosed with chlamydial infection. The national Centers for Disease Control and Prevention (CDC) defines EPT as "the practice of treating the sex partners of persons with sexually transmitted diseases (STD) without an intervening medical evaluation or professional prevention counseling."[1] New York State joined 14 states that allow EPT. It should be noted that the NYS EPT law provides for an expiration date upon which time it can be repealed, i.e. January 1, 2014.

The effort to allow EPT has gained support partly due to the rise of cases of chlamydia (Chlamydia trachomatis), the most commonly reported sexually transmitted infection in the US. The incidence of chlamydia has climbed each year since it became a reportable infection in 2000. This increase may actually be attributed to better reporting, more screening at point-of-care sites and improved diagnostic tools. Mandatory reporting coupled with increased case finding efforts have uncovered an epidemic far beyond original expectations. In the U.S., the 2007 national case rate of 370.2 cases per 100,000 population marked a significant increase over the 344.3 case rate reported in 2006. In Dutchess County and in New York State, chlamydia infection rates continue to rise (Figure 1).

FIGURE 1



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COMMUNICABLE DISEASES

Disease Incidence * (rate per 100,000 population)	Jan-Dec 2008 [1]		Jan- Dec 2007		Jan- Dec 2006		Jan- Dec 2005		Jan- Dec Avg ('05-'07)	
	Freq	Rate	Freq	Rate	Freq	Rate	Freq	Rate	Freq	Rate
ARTHROPOD-BORNE DISEASES										
Babesiosis	59	20.0	44	14.9	42	14.2	23	7.8	36	12.2
Ehrlichiosis [2]	94	31.8	85	28.8	132	44.7	174	59.0	130	44.0
Lyme Disease [2]	899	304.6	551	186.7	930	315.1	1398	473.7	960	325.3
BLOOD-BORNE PATHOGENS										
Hepatitis B, Chronic	12	4.1	35	11.9	48	16.3	52	17.6	45	15.2
Hepatitis C, Chronic	344	116.6	587	198.9	620	210.1	556	188.4	588	199.2
SEXUALLY TRANSMITTED INFECTIONS										
Chlamydia	574	194.5	599	203.0	462	156.5	483	163.6	515	174.5
Gonorrhea, total	73	24.7	106	35.9	122	41.3	111	37.6	113	38.3
Early Latent Syphilis	5	1.7	6	2.0	6	2.0	2	0.7	5	1.7
Primary/Secondary Syphilis	2	0.7	0	0.0	4	1.4	2	0.7	2	0.7
GASTRO-ENTERIC INFECTIONS										
Campylobacteriosis	25	8.5	30	10.2	28	9.5	27	9.1	28	9.5
Cryptosporidiosis	2	0.7	2	0.7	1	0.3	20	6.8	8	2.7
E.Coli 0157:H7	2	0.7	4	1.4	0	0.0	5	1.7	3	1.0
Giardiasis	32	10.8	20	6.8	33	11.2	31	10.5	28	9.5
Salmonellosis	33	11.2	46	15.6	30	10.2	45	15.2	40	13.6
Shigellosis	3	1.0	3	1.0	5	1.7	4	1.4	4	1.4
RESPIRATORY INFECTIONS										
Pertussis [2]	8	2.7	9	3.0	21	7.1	25	8.5	18	6.1
Streptococcus pneumoniae, invasive	26	8.8	42	14.2	34	11.5	28	9.5	35	11.9
Tuberculosis [3]	6	2.0	3	1.0	9	3.0	6	2.0	6	2.0

HIV and AIDS				
Cases diagnosed through 2007, **Excluding** prison inmates [4]	Prevalence[5]		Incidence[6]	
	Freq	Rate per 100,000	Freq	Rate per 100,000
HIV	239	81.6	29	9.9
AIDS	425	145.2	18	6.1

1 Based on month case was created, or December for cases created in Jan/Feb of following year.
2 Confirmed and probable cases counted; Lyme Disease probable cases only as of 2008.
3 Not official numbers.
4 Data are provisional; rates are calculated based on 2007 Population Estimates.
5 Cases presumed living with through December 2007. HIV prevalence are counted as living HIV (not AIDS) cases.
6 Reported to NYSDOH in 2007 (preliminary data as of August 2008).

** Rates are incidence rates (based on number of new cases for the reporting period).*
Data Source: New York State Department of Halth, Division of Epidemiology & Bureau of HIV/AIDS Epidemiology.

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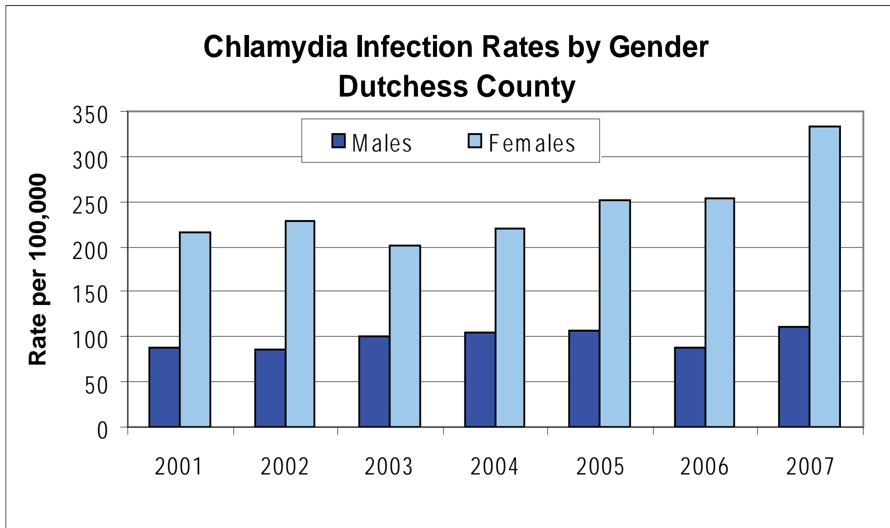
Further analysis of the data reveals that the burden of chlamydia infection is disproportionate. Women are three times more likely to have chlamydia than men (Figure 2).

FIGURE 2



Nearly 75% of infected women and 50% of infected men exhibit no clinical symptoms. However, if left untreated chlamydia can lead to arthritis, skin lesions, or inflammation of the eye and genital organs as well as the maternal child complications including; infertility, pelvic inflammatory disease and infant infection such as pneumonia and conjunctivitis. A broad and comprehensive public health response is necessary to reduce the burden of chlamydia.

Traditional control methods involve management of the sexual partner(s) by notification and referral to a public health clinic or their own medical provider. These activities are resource intensive and often ineffective in achieving treatment compliance in persons exposed. Expedited Partner Delivered Therapy (EPT) offers another option. EPT may include medication or a prescription provided by the health care professional to the infected person to deliver directly to their sexual partner(s). These contacts will then be treated without the benefit of medical evaluation and screening for other STDs including HIV.

Studies show that EPT may increase the treatment of infected individuals particularly those persons without symptoms or with limited access to medical care. These studies focused on heterosexual adult men and women.

Use of EPT in populations most at risk for chlamydia infection; adolescents, pregnant women and men-who-have-sex-with-men, has not been studied. EPT also does not account for STD co-morbidities in sex partners. Without an exam from a medical provider, other STDs may go undiagnosed. Additionally, the bacterial ecology of chlamydia could change significantly with unsupervised antibiotic use that could easily lead to antimicrobial resistance already rampant in healthcare. Unsupervised therapy creates the potential for allergic reactions, drug interactions and eliminates the opportunity for professional prevention counseling.

The Council of Ethical and Judicial Affairs (CEJA Report 6-A-08) of the American Medical Association (AMA) recommended several guidelines for physicians. [2]

1. To use of EPT should be considered only if the physician reasonably believe that a patient's partner(s) will be unwilling or unable to seek treatment within the context of a traditional patient-physician relationship.

2. If the physician chooses to initiate EPT, the patient must be provided with appropriate instructions and with educational materials to share with their partners. Information should include: disclosure of risk of potential adverse drug reactions; the possibility of dangerous interaction with other medications the partner may be taking; and the fact that the prescribed medicine would not treat other STDs they may be exposed to.

3. The physician should also make a "reasonable effort to refer a patient's partner(s) to appropriate health care professionals."

While New York State is finalizing its guidelines, additional information about Expedited Partner Delivered Therapy legislation in New York State can be found at www.cdc.gov

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Thanks to Andrew S. Rotans, MPH, Senior Public Health Advisor for assisting with this article.

1 www.cdc.gov/std/treatment/EPTFinalReport2006.pdf
2 http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_6a08.pdf

CLINIC SERVICES AND HOURS:
LOG ON TO WWW.DUTCHESSNY.GOV (HEALTH DEPT - SERVICES & PROGRAMS) OR
WWW.CO.DUTCHESS.NY.US/COUNTYGOV/DEPARTMENTS/HEALTH/HDINDEX.HTM

TELEPHONE NUMBERS: MAIN 845.486.3400 TTY 845.486.3417
EMAIL: HEALTHINFO@CO.DUTCHESS.NY.US

Service	Number
Communicable Disease Control Division	845.486.3402 (tel) 845.486.3564 (fax) 845.486.3557 (fax)
Tuberculosis Reporting & Info	845.486.3423
West Nile Virus Hotline	845.486.3438
Lyme Disease Hotline	845.486.3407
Rabies Prevention Program	845.486.3404
HIV Partner Notification Assistance	845.486.3498
HIV Testing & Counseling	845.486.3401
HIV Hotline	845.486.3408
Sexually Transmitted Disease Clinic	845.486.3401
Travel Immunizations	845.486.3504
Immunization Program	845.486.3409
Flu Hotline	845.486.3435

NEW YORK STATE DEPARTMENT OF HEALTH COMMUNICABLE DISEASE REPORTING REQUIREMENTS

Reporting a suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR2.10a). The primary responsibility rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions or other locations providing health services (10NYCRR 2.12) are also required to report. Case reporting forms can be downloaded from our website or by calling 845.486.3401.

Call 845.486.3402 for more information about reporting a communicable disease.

Any Comments or Suggestions?
healthinfo@co.dutchess.ny.us

Dutchess County
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