



STD EXAMINER

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Remarks from Dr. Richwald

As part of a continuing effort to restructure our department in the wake of the 1995 fiscal crisis, Department of Health Services Director Mark Finucane met with a group of DHS managers in late March to discuss improving Health Services. While committed to "protecting Public Health from further reductions," as he wrote in the 1997-98 DHS Budget Guidelines, Finucane challenged the group to fundamentally assess and "re-engineer" our program structures, activities and relationships outside of the DHS. For STD control services, this raised several questions:

1. Are staff in our STD clinics, STD field services and data collection being used as effectively as possible?
2. Are our PHP&S services geographically located to best address the burden of disease through surveillance, clinic care, and field services?
3. To what extent will our partnerships with community clinics and other community groups improve our disease control capacity?
4. Have PHP&S employees been actively involved in developing current activities and future directions?

STD Program staff will contribute to this re-examination in a number of ways. Headed by Dr. Robert Settlege, STD Program Medical Director, management staff is currently updating the 1987 STD Manual and renaming it, "STD Clinical and Prevention Practice Guidelines." In writing the new manual, we hope to identify necessary changes in STD care and procedures. Other Program staff is seeking input from health service providers in PHP&S, DHS and the community, in order

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Satellite Video Conference Provides Update on Viral STDs

Over thirty Los Angeles area health professionals gathered at the L.A. County STD/HIV Training Center on March 20, 1997 to take part in a live interactive video conference, "Update on Viral STDs: Genital Herpes and Human Papillomavirus," presented via satellite by the National Network of STD/HIV Prevention Training Centers.

The two-hour video conference featured a panel of national experts and emphasized the broad scope of the viral STD problem. "Rates of bacterial diseases such as gonorrhea and chancroid are declining," said Linda Fisher, MD, Chief Medical Officer, St. Louis County Department of Health and the conference moderator, "but viral sexually transmitted illnesses continue to increase." Fisher reported that over 40 million Americans are currently infected with HPV and at least 31 million with genital herpes. An additional 1.5 million new cases of these infections are acquired each year. Katherine Stone, MD, Chief of Epidemiology Research at the CDC Division of STD Prevention, noted that the costs associated with viral STDs are staggering. Conservative estimates of annual health care expenditures related to genital herpes and HPV total \$200 million and \$3 to \$4 billion, respectively.



The conference presenters provided state-of-the-art information on HPV and genital herpes clinical manifestations, diagnosis, treatment, counseling, partner management and pregnancy issues. They also answered viewers' questions in a live call-in session.

John Douglas, MD, Medical Director of the Denver Department of Public Health STD Clinic, discussed HPV. He differentiated between "low-risk" types of genital HPV, which can cause external genital warts, and "high-risk" types, which rarely produce visible warts and are related to the development of cervical, anal, vulvar, vaginal and penile cancers. Genital HPV can be found in 95% of cervical cancers, Douglas said. Discussing treatment for external genital warts, Douglas emphasized that currently available therapies are aimed at eradicating visible lesions, but do not cure HPV. He described new therapeutic developments, including Imiquimod (brand name, Aldara), a new patient-applied topical treatment recently approved by the FDA.

Discussing genital herpes,
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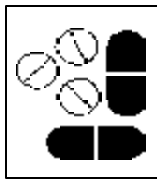
Clinical Corner

Azithromycin: Is it a Cost-Effective Treatment for Chlamydia?

Over the past few years, azithromycin—the single-dose treatment for chlamydia—has been heralded as a clinical breakthrough. Yet its high cost compared to other standard treatments for chlamydia has raised questions about the cost-effectiveness of its use in publicly-funded STD clinics.

Numerous studies have shown that single-dose azithromycin (brand name, Zithromax) is as clinically effective as a seven-day course of doxycycline in treating both urethral and cervical *Chlamydia trachomatis* infections in males and females. With treatments such as these which provide clinically comparable results, any difference in their effectiveness is directly related to patient compliance. Azithromycin is given orally as a single one-gram dose, allowing clinic staff to observe 100% patient compliance in taking the medication. Doxycycline must be taken orally twice a day for seven days, making compliance more uncertain.

Although studies consistently report high success rates after a multi-dose regimen of doxycycline (an estimated 80% in research study patients), this rate falls to 40% for patients outside research settings who do not receive constant reminders to take their medication. The compliance rate with a seven-day course of therapy is likely to be lowest among patients with asymptomatic chlamydial infections identified by routine screening or as a contact to an infected sex partner. Currently,



approximately 75% of women and 50% of men diagnosed with chlamydial infections at public STD clinics are asymptomatic for chlamydia.

The major drawback to azithromycin is cost; it retails for approximately four to eight times the price of doxycycline. Nevertheless, a recent study, “The Cost Effectiveness of Azithromycin for *Chlamydia trachomatis* Infections in Women,” (Hillis, et al., *Journal of STDs*, Sept-Oct 1995) concludes that azithromycin is a more cost-effective treatment than doxycycline for publicly-funded clinics. The study suggests that while azithromycin is more expensive in the short-term, the initial cost does “not fully realize the potential savings [associated with greater compliance] from reducing the costs of PID, ectopic pregnancy, infertility and chronic pelvic pain.”

According to Dr. Gary Richwald, Director of the STD Program, the effectiveness of azithromycin also greatly depends on clinicians communicating to patients that they are not immediately cured by the single-dose treatment. “Clinicians must emphasize how critical it is for patients to abstain from sex for seven days *and* have all sex partners tested and treated if infected.”

Overall, Richwald believes that azithromycin’s benefits outweigh its costs: “In STD clinics and other situations where patient compliance cannot be assumed, the STD Program promotes azithromycin as the best possible treatment for chlamydia.”

Satellite Conference

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Hunter Handsfield, MD, Director of STD Control, Seattle-King County Public Health Department, spoke about the importance of subclinical or asymptomatic herpes, now thought to be the most common type of infection. “Transmission of herpes occurs predominantly from those people who didn’t know they were infected,” he said. He urged healthcare providers to discuss episodic and daily suppressive treatment options with patients, taking their cue from patients’ perceptions of the disease’s severity. New developments in herpes treatment were described, including the availability of Valacyclovir (brand name, Valtrex) and Famciclovir (Famvir), longer-acting variants of Acyclovir.

Several panelists stressed the importance of risk assessment, patient/partner counseling and behavioral interventions in the control of viral STDs. Katherine Stone reported that while efforts are underway to develop vaccines to treat and prevent HPV and HSV, successful vaccines are still several years off. King Holmes, MD, Professor of Medicine at the University of Washington, summed it up, “We really are in an era where behavioral interventions to

prevent exposure have become more important than almost anything we can do to control these viral STDs.”

To borrow a videotape of this video conference, contact Philip Phan, L.A. County STD Program, at (213) 744-5952. The next video conference, “HIV Prevention Update: Key Issues in Counseling and Testing”, is scheduled for May 22, 1997 from 10:00 am to 12:30 pm. Space is limited; for information contact George Smeitana, L.A. County STD/HIV Training Center, at (562) 923-3042.

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to re-examine our core STD-control functions. This will culminate in an STD Strategic Plan through the year 2000. With the implementation of our new surveillance system, STD*Casewatch, in 1997, we will greatly improve the quality and availability of data needed to assess STD morbidity and individual field-staff performance.

Most important to these efforts is open communication among all DHS staff. It is clear that we need to be diligent in addressing anticipated difficulties and seek innovative solutions to our problems. I am hopeful, however, that we will rise to Mr. Finucane’s challenge.



Clinical Corner

New Treatment for External Genital Warts

Imiquimod—an innovative treatment for external genital warts (EGWs)—has recently been added to the PHP&S STD formulary. Under the brand name, Aldara, Imiquimod 5% cream is the newest available treatment for removing external genital and perianal warts.

“Aldara cream represents a significant breakthrough in the management of this common problem,” says Dr. Robert H. Settlege, Medical Director of the STD Program, “It greatly expands our patient-applied treatment options.”

Among the 135 million men and women from 15 to 49 years of age in the U.S., an estimated 15% (20 million) are currently infected with genital human papilloma virus (HPV), which causes EGWs. Over 1.4 million individuals have EGWs, and the remainder, subclinical infection. HPV is the fastest growing sexually transmitted infection in the U.S., with 500,000 to one million new infections each year.

Although there is no cure for genital warts, and cases can have recurrent outbreaks, treatment can alleviate physical signs and symptoms such as itching, burning, pain and tenderness. It may also ease the embarrassment, worry, fear, anger and other psychological reactions to having EGWs.

Until recently, available treatments for genital warts included removing them by chemical agents such as TCA, loop electrocautery excision (burning), excisional surgery, laser ablation, cryotherapy (freezing), interferon injections, and tissue-destructive drugs such as podofilox and podophyllin--the modality most frequently used in our STD clinic system. These treatments have been associated with local skin reactions; pain, burning and itching are the most commonly reported adverse effects.

Marketed by 3M Pharmaceuticals, imiquimod is newest in a class of drugs called immune response modifiers. In a double-blind, vehicle-controlled clinical trial with 209 patients, 109 received imiquimod cream and 100 received vehicle cream. Females using imiquimod experienced a 72% clearance rate of treated warts, compared to 20% for those using vehicle. In the male treatment group, 33% of males using imiquimod experienced complete clearance of their warts, compared to 5% for those using vehicle. The median time to complete warts clearance was ten weeks.

Imiquimod cream is patient-applied prior to bedtime, every other day, 3 times per week and left on for 6 to 10 hours. The cream is then removed with soap and water. Treatment continues until there is a total clearance of the warts or for a maximum of 16 weeks. Each gram of the 5% cream contains 50 mg of imiquimod in a vanishing cream base. One month's therapy comes in a box of 12 single-dose packets.

In clinical trials, imiquimod cream has been generally well-tolerated. Most patients experienced only mild to moderate skin reactions in the wart area. The most frequent reaction has been redness (erythema) at the treatment site. Only 4% of patients reported pain and less than 2% of patients discontinued use due to skin reactions.

There are no known contraindications to the use of Aldara cream. It has not been fully evaluated for the treatment of internal genital/internal anal disease such as urethral, intra-vaginal, cervical, rectal, or intra-anal HPV, however, and is not recommended for these conditions. Treatment guidelines for the use of imiquimod should be available in the near future from the PHP&S Pharmacy Committee.

Impact Assessment Team Reports Findings

Last month the Public Health Crisis Impact Assessment (IA) Team, a group of researchers studying how L.A. County's October 1995 fiscal crisis and health services restructuring has affected STD prevention and control, released findings from the first phase of its research. Their report, “Los Angeles County Public Health Crisis: Report of the STD Clinic Provider Survey,” contains results from in-depth interviews conducted with staff at the Department of Health Services' eleven remaining STD clinics, which were reduced from 29 clinics before the crisis.

From July through September, 1996, the IA team interviewed 64 STD clinic staff, including clinicians, field staff, nurses and administrators. Respondents were asked about changes in job responsibilities, STD clinic operations, patient access to STD care, and quality of care since October 1995, as well as their recommendations for the future.

“The good news is that DHS staff have great ideas and intense commitment to their work,” says Marjorie Sa'adah, Director of the IA Project. “The bad news is that they

overwhelmingly believe that restructuring has adversely affected access to STD care in Los Angeles County.”

Staff reported that remaining STD clinic sites were not located in the areas of greatest need, as the areas that lost the most STD clinic sessions were high STD morbidity districts. Existing barriers to patient access, such as transportation difficulties, were amplified by the restructuring, respondents

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(3) promoting effective sex and needle-sharing partner notification and services, and (4) assuring clients are supported in changing their risk behaviors for STDs.

To effectively re-engineer the management of STD control in the Department of Health Services, we need to immediately improve our assessment of STD field services. This includes understanding available work-force, resources, actual workload, performance levels, and training needs. STD Program staff look forward to working closely with PHI, PHN, DIS, as well as the other Disease Control Programs, to meet the demands of a newly unfolding public health landscape.

Juvenile Court Health Services Moves to LAC+USC

On March 31, 1997, L.A. County Juvenile Court Health Services (JCHS) was transferred from its longtime organizational home in Public Health Programs and Services (PHP&S) to a new placement in LAC+USC Medical Center Pediatric Services. JCHS provides preventive and clinical health care for youth in facilities operated by the Probation Department and the Department of Children and Family Services (DCFS).

Because of the importance of the juvenile justice population to STD control, the STD Program is monitoring the transition closely. Dr. Lawrence M. Opas, Department Chief of Pediatrics at LAC+USC and Acting Director of JCHS, says, "I'm fully aware of the enormity of the STD problem that exists in the juvenile halls. I'm trying to gather as much information as I possibly can before I make decisions about services within JCHS." Opas is part of an oversight committee of JCHS and LAC+USC Medical Center staff which is meeting frequently to prepare new memoranda of understanding between JCHS, DCFS and the Probation Department by July 1, 1997. The transition process has included meetings with representatives of programs which collaborate with JCHS in the provision of health services, including Dr. Gary Richwald, STD Program Director.

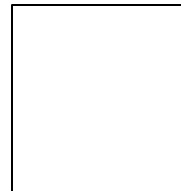
The STD Program currently operates several signifi-

cant disease control projects at the juvenile halls in collaboration with JCHS staff. These include the STD Intervention Project for Incarcerated Female Youth (Project YES!), the ligase chain reaction (LCR) chlamydia screening project, and the CDC STD Prevalence Monitoring Project. STD Program staff also provide partner notification services to youth in these facilities.

The juvenile hall facilities are seen as critical sites for STD control efforts because STD morbidity in juvenile detainees is exceeded only by rates in STD clinic patients. While teenagers in general are a high-risk group for acquiring STDs, risk factors for these diseases are magnified among incarcerated youth. Juvenile detainees are typically sexually active, have high rates of alcohol and drug use, and have often been victims of physical and emotional abuse. "With about 30,000 admissions each year, the juvenile halls provide the STD Program with a unique opportunity to access these highest-risk youth," says Dr. Richwald.

Dr. Opas is hopeful that JCHS's organizational shift will provide additional benefits to these youth. He says, "It is my goal to find ways Personal Health Services can be used to improve the efficiency of juvenile health services in a way that's complementary to the impressive work done here by PHP&S over the past twenty years."

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