

Louisiana



REPORTED MORBIDITY
JANUARY, 1984

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF HEALTH SERVICES AND ENVIRONMENTAL QUALITY
BOX 60630 NEW ORLEANS, LOUISIANA 70160

MONTHLY MORBIDITY REPORT

Provisional Statistics

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PUBLIC HEALTH STATISTICS and
DIVISION OF DISEASE CONTROL

RECOMMENDED CHANGES IN TREATMENT OF GONORRHEA AND PELVIC INFLAMMATORY DISEASE*

TREATMENT OF GONORRHEA

Because of the changing sensitivity of the gonococcus (increasing incidence of Penicillinase Producing Neisseria Gonorrhoe [PPNG], reports of emergence of tetracycline resistant gonococci in several areas) and the high frequency of coexisting chlamydial and gonorrheal infections it became necessary to change the guidelines for treatment of gonorrhea.

These guidelines are not a list of all possible treatment regimens. Rather they provide guidance for regimens that meet general criteria of efficacy, safety, ease of administration and cost.

In recommending treatment the following factors should be considered:

- 1) Patient preference may influence their compliance with surveillance or willingness to return for care for future infection.
- 2) Single dose is preferable for those who may be unreliable in completing multiple dose regimens.
- 3) Effectiveness of antibiotic:

Some side effects, such as penicillin allergy, involve specific individuals whereas others have more general impact. For instance, tetracyclines should never be

(continued on page 2)

BULLETIN

NATIONAL NEONATAL HERPES SIMPLEX SURVEILLANCE PROGRAM

The Center for Disease Control (CDC) of the United States Public Health Service, Department of Health and Human Services, is initiating a national neonatal herpes simplex virus (HSV) surveillance system. An attempt will be made to identify every case of neonatal HSV infection occurring in infants born after September 30, 1983. Health professionals are asked to report all cases of suspected or confirmed HSV

infection that occur in infants within 30 days of life. Neonatal HSV is a devastating infection, and CDC is attempting to describe the magnitude of the problem and to identify possible means of prevention.

To report a case or for further information, call Louise Ritz or Gail Bassin Stempler, collect, at (301) 589-6760.

* SOURCE: Sexually Transmitted Disease Control Manual, DHHR, Office of Health Services and Environmental Quality, Venereal Disease Control Section, Revised January, 1984.

RECOMMENDED CHANGES IN TREATMENT OF
GONORRHEA AND PELVIC INFLAMMATORY DISEASES (continued from page 1)

used for treating young children or pregnant women. In these cases, erythromycin or spectinomycin may be used for the penicillin-allergic patient.

The value of procaine penicillin against incubating syphilis, or of tetracycline against non-gonococcal urethritis may be relevant, depending on the prevalence of these diseases in any community. While the recommended parenteral penicillin treatment for gonorrhea will probably abort incubating syphilis, it will not adequately treat non-gonococcal urethritis. In turn, therapy with the recommended tetracycline regimen will treat non-gonococcal urethritis, but may not abort incubating syphilis.

Physicians are cautioned to use no less than the recommended dosage of antibiotics.

Uncomplicated Gonococcal Infections in Men, Women and Sexual Partners:

Men and Women infected or exposed to gonorrhea should be examined, cultured and treated at once.

A. COMBINED AMPICILLIN TETRACYCLINE:

An important concern in the treatment of gonorrhea is coexisting chlamydial infection which has been documented in up to 40% of patients with gonorrhea. A 7.5 day treatment with tetracycline is effective against both bacterial infections but patient compliance can be a problem with the multiple day tetracycline regimen for gonococcal infections as can the potential selection of tetracycline resistant isolates when incomplete doses are taken. To address these concerns, a single dose regimen of ampicillin could be administered before the tetracycline regimen.

AMPICILLIN

3.5 gm by mouth together with 1 gm probenecid by mouth administered at the same time.

PLUS

TETRACYCLINE HYDROCHLORIDE (HCL)

0.5 gm by mouth 4 times per day for 7.5 days. See below for precautions.

B. AMPICILLIN

3.5 gm by mouth, together with 1 gm probenecid by mouth administered at the same time. There is evidence that this regimen may be slightly less effective than the recommended APPG regimen, however, it has the advantage of being administered orally and of avoiding the risk of a procaine reaction.

Ampicillin is NOT EFFECTIVE FOR ANORECTAL OR PHARYNGEAL INFECTIONS.

C. TETRACYCLINE HYDROCHLORIDE

0.5 gm by mouth 4 times per day for 7.5 days (total dosage 15.0 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as single-dose therapy. Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given one hour before or two hours after meals. Tetracyclines should not be used to treat pregnant women or children less than 8 years of age

Tetracycline is NOT EFFECTIVE FOR ANORECTAL INFECTIONS.

DOXYCYCLINE HYCLATE

100 mg by mouth twice a day for 7 days. The doses may be administered with food, including milk and carbonated beverages.

D. AQUEOUS PROCAINE PENICILLIN G - (APPG)

4.8 million units intramuscularly divided into a least 2 doses and injected at different sites at one visit, together with 1 gm of probenecid by mouth just before injections.

SPECIAL NOTES

PATIENTS ALLERGIC TO PENICILLIN should not be treated with Ampicillin or APPG.

PREGNANT WOMEN AND CHILDREN BELOW THE AGE OF 8 should not be treated with Tetracycline or Doxycycline.

PHARYNGEAL INFECTIONS do not respond to Ampicillin or Spectinomycin but usually do respond to APPG or Tetracycline.

ANORECTAL INFECTIONS do not respond to Ampicillin or Tetracycline but respond to APPG, or Spectinomycin. This should be taken into consideration when treating homosexual men.

When necessary the following treatment regimens have also proven effective:

A. SPECTINOMYCIN HYDROCHLORIDE

2 gm intramuscularly in 1 injection. It is recommended that this regimen be reserved only for penicillin resistant strains of gonorrhea and other treatment failures. It should not be used routinely since spectinomycin resistant strains could result. In pregnant females, allergic to penicillins, spectinomycin is the drug of choice. Spectinomycin labels indicate "Safety for use in pregnancy has not been established", however, it seems that in single dose no complications occur.

B. ERYTHROMYCIN

Is less often recommended as it is less effective than above regimens. Erythromycin carries the same label as Spectinomycin regarding usage in pregnancy. It is administered at doses of 0.5 gm by mouth 4 times per day for 7 days. In pregnant women erythromycin would treat coexistent chlamydial infection.

C. CEPHALOSPORINS

Very effective against *N. gonorrhoeae* but should be reserved for treatment of PPNG. They are ineffective against pharyngeal and anorectal infections.

D. TRIMETHOPRIM/SULFAMETHOXAZOLE

(80 mg/400 mg) Administered as a daily single dose of 9 tablets for 5 days is effective against all forms of gonorrhea. It should be reserved for treatment of PPNG pharyngeal infection. Not to be used in pregnant women.

TREATMENT OF GONOCOCCAL PELVIC INFLAMMATORY DISEASE (GPID)

The treatment of choice is not established. No single agent is active against the entire spectrum of pathogens. Several antimicrobial combinations do provide a broad spectrum of activity against the major pathogens in vitro - but many have not been adequately evaluated for clinical efficacy in PID.

FOR OUTPATIENTS

APPG 4.8 million units intramuscularly or AMPICILLIN 3.5 gm or AMOXICILLIN 3.0 gm each with probenecid 1.0 gm. Either regimen is followed by DOXYCYCLINE 100 mg by mouth twice a day for 14 days or TETRACYCLINE HCl 500 mg, 4 times a day for 14 days. This is less effective against certain anaerobes and require more frequent dosing.

Patients with PID due to PPNG should be treated with 2 gm SPECTINOMYCIN daily for 5 to 10 days. This regimen may be combined with TETRACYCLINE to complete 10 days of therapy.

In more complicated cases or if other bacteria were thought to be significantly involved other medications may be necessary.

HOSPITALIZED PATIENTS

Treatment has to be adapted to the bacteria involved in the PID process.

The predominant anaerobic bacteria involved is Bacteroides fragilis which is resistant to penicillins, cephalosporins, tetracyclines and aminoglycosides. Effective anti-bacterials include metronidazole, clindamycin and chloramphenicol. Of these it would seem that metronidazole would be the drug of choice because of its rapid bactericidal activity, good diffusions throughout body tissues and fluids, absence of serious toxicity, stability and price.

The other predominant aerobic bacteria is E. Coli. Aminoglycosides (kanamycin, gentamicin) are very effective against E. Coli.

REGIMEN OPTIMAL FOR GONORRHEA (PPNG INCLUDED) AND CHLAMYDIAL INFECTION

DOXYCYCLINE

100 mg IV twice a day

Plus

CEFOXITINE

2.0 gm IV, 4 times a day for at least 4 days or 48 hrs after patient defervesces.

Followed by

DOXYCYCLINE

100 mg by mouth twice a day for 14 days.

REGIMEN OPTIMAL FOR ANAEROBES AND CHLAMYDIAL INFECTION

DOXYCYCLINE

100 mg, IV twice a day

Plus

METRONIDAZOLE

1.0 gm IV twice a day for at least 4 days or 48 hrs after patient defervesces.

Followed by

The same two drugs at same dosage orally for 14 days.

REGIMEN OPTIMAL FOR ANAEROBES AND FACULTATIVE GRAM NEGATIVE RODS

CLINDAMYCIN

600 mg, IV, 4 times a day

Plus

GENTAMICIN OR TOBRAMYCIN

2.0 mg/kg, IV, followed by 1.5 mg/kg IV 3 times a day in patients with normal renal function. For at least 4 days or 48 hrs after patient defervesces.

Followed by

CLINDAMYCIN

450 mg by mouth, 4 times a day for 14 days.

TREATMENT SHOULD BE INITIATED AS SOON AS THERE IS REASONABLE CLINICAL JUSTIFICATION TO MAKE A DIAGNOSIS OF GPID WITHOUT WAITING FOR THE RESULTS OF THE CULTURE.

Consideration should be given to remove any IUD that would be present.

SELECTED REPORTABLE DISEASES (By Place of Residence)

STATE AND PARISH TOTALS	VACCINE PREVENTABLE DISEASES					ASEPTIC MENINGITIS	HEPATITIS A AND UNSPECIFIED**	HEPATITIS B	LEGIONELLOSIS	MALARIA ***	MENINGOCOCCAL INFECTIONS	SHIGELLOSIS	TUBERCULOSIS, PULMONARY	TYPHOID FEVER	OTHER SALMONELLOSIS	UNDERNUTRITION SEVERE	GONORRHEA	SYPHILIS, PRIMARY AND SECONDARY	RABIES IN ANIMALS (PARISH TOTALS CUMULATIVE, 1984)
	MEASLES	RUBELLA*	MUMPS	PERTUSSIS	TETANUS														
TOTAL TO DATE 1983	0	0	0	0	1	0	21	21	0	0	5	0	34	0	7	0	1469	138	1
TOTAL TO DATE 1984	0	0	0	0	0	0	6	5	0	0	2	2	21	0	4	1	2513	114	0
TOTAL THIS MONTH	0	0	0	0	0	0	6	5	0	0	2	2	21	0	4	1	2513	114	0
ACADIA																	6		
ALLEN																	9		
ASCENSION																	7		
ASSUMPTION																	2		
AVOUELLES																	1	2	
BEAUREGARD																	6		
BIENVILLE																	2		
BOSSIER																	7	3	
CADDO												1					250	8	
CALCASIEU												1					77	2	
CALDWELL																	5		
CAMERON																	2		
CATAHOULA																	2		
CLAIBORNE																	2		
CONCORDIA																	3		
DESOTO																	4	1	
EAST BATON ROUGE																	166	10	
EAST CARROLL																	11		
EAST FELICIANA																	3		
EVANGELINE																	1		
FRANKLIN																	8		
GRANT																			
IBERIA																	9	1	
IBERVILLE																	4		
JACKSON																	1		
JEFFERSON											1	1	3		1		181	5	
JEFFERSON DAVIS												1			1		11		
LAFAYETTE							2										57	3	
LAFOURCHE																	12		
LASALLE																			
LINCOLN																	8		
LIVINGSTON											1						1		
MADISON																	17	2	
MOREHOUSE																	30		
NATCHITOCHE																	5	1	
ORLEANS								3				9					957	46	
OUACHITA																	126	4	
PLAQUEMINES																			
POINTE COUPEE																	2		
RAPIDES												2					105	5	
RED RIVER																	2		
RICHLAND																	19		
SABINE																	3		
ST. BERNARD																	3		
ST. CHARLES																	11	1	
ST. HELENA																			
ST. JAMES																	17	1	
ST. JOHN												1					7		
ST. LANDRY																	23	2	
ST. MARTIN												1					8	2	
ST. MARY																	4	1	
ST. TAMMANY								2				1					14	2	
TANGIPAHOA							2					1					19	4	
TENSAS																	1		
TERREBONNE							1										25	2	
UNION																	7		
VERMILION															3		4	2	
VERNON													1				213	1	
WASHINGTON																	13		
WEBSTER																	8	3	
WEST BATON ROUGE																			
WEST CARROLL							1										2		
WEST FELICIANA																	4		
WINN																	2		
OUT OF STATE																	4		

* Includes Rubella, Congenital Syndrome.

** Includes Hepatitis Non A, Non B.

*** Acquired outside United States unless otherwise stated.

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