NOTES TO CENTERFOLD

* The asterisk denotes infections that by law must be reported in Oregon.
1. The safety during pregnancy has not been established.
2. Treatment may be extended if healing is incomplete after 10 days of therapy.
3. Appears to be less effective that other tetracyclines regimens in persons with very frequent occurrences (10 episodes/year).
4. Multnomah County STD Program recommends a second injection given 7-10 days later for secondary syphilis and for early latent syphilis.
5. Tetracyclines are contraindicated for pregnant or lactating women, and for children.
6. The safety and efficacy of azithromycin has not been determined for pregnant or lactating women, or for children < 8 years of age, and less than 45 kg. Preliminary data indicates that azithromycin may be safe and effective in pregnant, but data are insufficient to recommend routine use in pregnant women.
7. Because mixed infections are so common, empiric therapy for Chlamydia is recommended for persons with gonorrhea; azithromycin is not effective against N. gonorrhoeae.
8. Quinolones are contraindicated for pregnant or lactating women, or for children.
9. Erythromycin estolate is contraindicated in pregnancy.
10. Not recommended against pharyngeal gonorrhea. Person treated with these regimens for known or suspected pharyngeal gonorrhea must have follow-up throat cultures to verify eradication of infection.
11. Patient should be advised to avoid consuming alcohol during and 24 hours following treatment with metronidazole.
12. The creams and suppositories are oil based and might weaken latex condoms and diaphragms; refer to condom labeling for additional product information.
13. The use of idoxuridine vaginal cream during pregnancy is not recommended.
14. Do not use metronidazole gel in persons allergic to metronidazole.
15. High risk women are those who have previously delivered a prematurity infant. Some experts recommend treatment of asymptomatic BV in high risk women after the first trimester to prevent premature delivery, while others believe more information is needed before a recommendation can be made.
16. This regimen has lower efficacy for bacterial vaginosis (BV). 17. Available over the counter without a prescription.
18. Consult the full guidelines for management of pediculosis of the eyelashes.
19. Do not use lindane in pregnant or lactating women, or children < 2 years old. Do not use lindane lotions or cream after a bath or in persons with extensive dermatitis.
20. Consult the full guidelines for management of bedding and clothing.

Reporting Abortion Complications

Abortion is an issue that generates considerable public and policy debate. The role of the Health Division in these debates is to provide data as required by law that is as accurate and complete as possible to inform public debate on this issue. Our ability to fulfill that role is dependent upon the cooperation of health care providers in reporting to us.

This is a reminder that in addition to reporting induced terminations of pregnancy to the Health Division, the fact that a follow-up visit has occurred, and whether any complications were noted are required by statute (ORS 435.496) to be included in that report.

Each induced termination of pregnancy that occurs in Oregon, regardless of the length of gestation, must be reported after two weeks but within 30 days of the termination. Reporting must be done by the person in charge of the institution in which the termination was performed, or, if the termination was performed outside an institution, by the attending physician. In addition, the person filing the report must also include information they have about follow-up visits or complications. Health care providers who perform a follow-up visit or see a patient with a complication should therefore provide that information to the person filing the report with the Health Division.

Reports should be sent to the Center for Health Statistics on form 45-113, Report of Induced Termination of Pregnancy. Forms can be ordered by fax (503/731-4084) or phone (503/731-4027); you can also download them from the Internet: http://healthoregon.org/chs/abortion.htm.

STD TREATMENT GUIDELINES

From 1980 through 1995, gonorrhea rates dropped precipitously (from 11,162 cases in 1980 to 854 cases in 1995). In the past few years, this trend has ended, with tallies steady or slightly increased (880 cases in 1998, 906 in 1999). Relative to the rest of the state, rates are high among black Oregonians (>400 cases per 100,000 population). Among reported cases, there is a 2.8:1 female to male ratio, in part due to active CT screening programs for young women. Rates are high across most of the state (see map)—particularly so in Jefferson and Multnomah Counties. Routine screening of sexually active females between the ages of 15 and 24 is critical, since three-fourths of infected women are asymptomatic. Twenty to 40% of untreated women with chlamydial infection will develop PID, which can lead to scarring of the fallopian tubes with attendant infertility, increased risk of tubal pregnancy, and chronic pelvic pain. Because of the complications of untreated CT infections, every 51 spent in screening and treatment saves an estimated $12 in medical costs.

Chlamydia Incidence by County, 1999

Several factors contribute to the ongoing epidemic of STDs, including the lack of appropriate screening and treatment, not to mention a surplus of licentiousness. Even when STDs are considered and properly diagnosed, patients may not receive appropriate treatment. The highlights of the 1998 STD Treatment Guidelines have been distilled into a Quick Summary table, which appears as the centerfold in this special double edition of the CD Summary—sure to become a collector’s item.

REFERENCES


Gonorrhea Incidence Rates, 1980–99

If you need this material in an alternate format, call us at 503/731-4024.
### STD SYNDROME

<table>
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<tr>
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### EPIDIDYMITIS

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**Sources**

The information in this table is based on the CDC’s 1998 Guidelines for Treatment of Sexually Transmitted Diseases. MMWR 1998;47(RR-1):1-127. The big enchilada can be downloaded from the CDC’s web site (ftp://ftp.cdc.gov/pub/Publications/mmwte/rr4701.pdf). This particular layout is derived from a summary chart developed by Mary Ann Ware MD, Medical Director of the Multnomah County STD Program. We thank her for allowing us to share this with you.