MINUTES OF THE BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES, STATE OF CALIFORNIA

Violet Varona-Lukens, Executive Officer
Clerk of the Board of Supervisors
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

Director of Public Health

At its meeting held February 11, 2003, the Board took the following action:

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Charles M. Jackson, Custody Chief and Dr. John Clark, Chief Physician, Los Angeles County Sheriff's Department made a verbal presentation to the Board regarding the status of the highly infectious skin disease called methicillin-resistant Staphylococcus aureus (MRSA) outbreak in the County Jails, and answered questions posed by the Board. Dr. Jonathan Fielding, Director of Public Health made a verbal presentation to the Board regarding MRSA and syphilis among men who have sex with men, as further detailed in the attached statement and memo dated February 11, 2003 and February 10, 2003, respectively.

Michael Weinstein, Dr. Paul Denouden, Karen Mall, Terri Ford and Ged Kensler, representing AIDS Healthcare Foundation, Dr. George Ayala and Daniel C. Montoya, representing AIDS Project Los Angeles and Genevieve Clavreul addressed the Board.

After discussion, by common consent, and there being no objection, the Board requested the Director of Public Health to:

1. Report back to the Board with biweekly written reports on the issues raised at the meeting on the methicillin-resistant Staphylococcus aureus (MRSA) and Syphilis outbreaks, including the provision of information about MRSA at all newborn facilities and at the County's Jail Intake Centers; and

(Continued on Page 2)

2. Work with the Sheriff to develop a protocol for daily hygiene by the inmates in County jail facilities.

5021103-a60

Attachments

Copies distributed:
Each Supervisor
Sheriff
Chief Administrative Officer
County Counsel
Director of Health Services

Status on Methicillin-resistant *Staphylococcus aureus* in the Jails

Statement by Jonathan E. Fielding, M.D. to the Los Angeles County Board of Supervisors

February 11, 2003

Staphylococcus aureus, a ubiquitous skin bacterium and often referred to as "Staph", is found on 30-50% of adults at any one time. Staph commonly causes skin infections such as boils, pimples or abscesses though occasionally it can cause more serious infections when it gets into the blood. Methicillin-resistant *Staphylococcus aureus*, or MRSA, is a strain of Staph that has developed resistance to a family of antibiotics, including penicillin and cephalosporins, which are commonly used to treat skin infections. MRSA is primarily spread skin to skin though it may also be spread by contaminated equipment and personal items. MRSA is common in healthcare facilities but more recently outbreaks have been reported in community settings such as athletic teams and correctional facilities. The health department has been investigating outbreaks of MRSA in hospitals since the 1970s and in nursing homes since the 1980s.

In June of 2002, the Acute Communicable Disease Control (ACDC) unit of Public Health was notified of an increased number of MRSA wound infections among inmates at the County Jail. Personnel at the Jail noticed an increase in February but attributed the increase to spider bites. No biting spiders were captured but, according to jail personnel, pesticides were applied.

We requested more information about the number of inmates, gender, age, location of the inmate at the time of the positive MRSA culture, and date of positive culture, and the antibiotic resistance pattern of each culture. Based on the review of the epidemiologic data from February-July, 2002, and consultations with the Centers for Disease Control and Prevention (CDC) in Atlanta, the California Department of Health Services, the California Department of Corrections, and the Georgia Department of Human Resources, (whose prisons had experience with the problem) recommendations for the control of MRSA were developed for the LA County Jail. These recommendations were sent to the Sheriff's Department on August 7th.

The recommendations included surveillance for skin infections in new inmates; appropriate wound care and antibiotic treatment of skin infections; increasing the frequency of environmental cleaning, showers, clean laundry; reducing movement of infected inmates; and education of inmates and staff. A summary of the recommendations is provided in Attachment A.

From August to the present time, we have continued to work with the Sheriff's Department on MRSA. We review monthly data about the number and location of MRSA cultures in the jail, follow trends in antibiotic resistance, and analyze the data to determine how many inmates enter the jail with MRSA infections. We are also reviewing charts of inmates who have been hospitalized with MRSA at LAC-USC to better understand the severity of these infections.

Based on the analysis of the data for 2002, 920 inmates were diagnosed with MRSA wound infections. Eighty-seven percent of the infections were in men. Inmates with wound infections came from all facilities. The number of first-time MRSA wound infections varied from a low of 54 cases in January 2002 to a high of 114 cases in October (Figure 1). Significantly, 9% of the wound infections occurred within 5 days of an inmate being admitted to jail, implying that the inmate was infected before they went to jail.

The hospital data showed that 67 inmates had MRSA wound or blood cultures while on the hospital jail ward in 2002. Review of 39 charts reveals that all the inmates were hospitalized with MRSA wound infections but 10 later had invasive disease including blood, bone and heart valve infections. The average length of stay was 13 days. Analysis of blood and wound cultures from the jail ward in the hospital shows that MRSA was uncommon in 1998 but increased significantly in 2001 (Figure 2).

Staff from the ACDC program have made multiple presentations at the Jail, including grand rounds to medical staff, and presentations to Commanders, Captains, deputies, nurses, microbiologists, and others about the outbreak and control recommendations. The Sheriff's Department is working with ACDC on a MRSA Task Force to better implement of the recommendations.

Public Health staff have also been investigating an outbreak of MRSA in men who have sex with men (MSM). On November 22, 2002, physicians from two large infectious disease clinical practices notified Public Health of increased numbers of MRSA skin infections among predominantly HIV-positive MSM. To address the concern of MRSA skin infections among MSM, we have increased surveillance in selected infectious diseases clinics and have begun a study of risk factors for infection among this population.

Recently MRSA cultures from the jail have been submitted for molecular fingerprinting and have been found to have the same molecular fingerprint as the MSM investigation and 2

other closed outbreaks that ACDC investigated in an athletic team (September) and in a newborn nursery (April). However, we do not know if any of these outbreaks are directly linked. The molecular fingerprint is consistent with that of other MRSA community outbreaks from other parts of the county. Isolates from all the outbreaks have been sent to CDC to characterize their virulence factors and toxins.

Control of MRSA in the Jail will not be easy for several reasons. Some inmates come into the jail with the infection and may not be identified before they spread the disease. There is rapid movement of inmates throughout Jail facilities. Close living conditions in the jail facilitate transmission of many diseases including meningococcal, pneumococcal, scabies, and MRSA. Finally, those that leave the jail may not finish their medications or wound treatment.

Several other jail and prison systems have had outbreaks of MRSA, including San Francisco, San Diego, Texas, Georgia, Mississippi, and Tennessee. Their experiences show that control of MRSA requires concerted efforts of many parts of the jail system. Facilities that have had success in controlling MRSA are prisons where the population is much more stable. It is much harder to control a person-to-person spread disease in a population that has a high turnover. Improved medical treatment alone is insufficient. Surveillance and treatment for skin infections must start when inmates are first admitted to the jail. Prevention of skin infections depends on inmate education and daily access to showers, soap, and increasing frequency to clean laundry. Dorms and cells need to be cleaned daily, especially when cases of MRSA are identified in a specific area. Items that have been exposed to MRSA that cannot be washed, such as torn mattresses, should be thrown out. Inmates undergoing treatment for MRSA should not be moved facility to facility. Continuing education of the Medical and Custody staff about the importance of MRSA and facilitating MRSA control measures is needed. Finally, a plan should be developed for discharging inmates with active MRSA infections to ensure that they have appropriate medical care (e.g. wound care, antibiotics) when they leave the jail. The ACDC-Jail MRSA Task Force has been looking into all of these issues and meets regularly to develop and implement specific control measures.

Despite all these interventions, it may not be able to completely eradicate MRSA from the jail. Inmates will continue to be admitted to the Jail with skin infections. There is significant turnover of inmates and there are multiple facilities in the Jail each with its own barriers for successful control. Furthermore, people are commonly colonized with Staph and it is not cost

effective to try to eliminate staph from the skin of everyone in the jail or do cultures to check if inmates or staff members are colonized. What will be needed is continued vigilance in identifying inmates with skin infections and quickly treating them and covering their wounds; maintaining access to showers and clean laundry; environmental cleaning; and continued education of staff and inmates.

To help assure early identification of possible additional outbreaks other than in health care facilities, we are undertaking a physician educational campaign on diagnosis and treatment of MRSA. We are also asking physicians to report any cluster of cases to us.

MRSA Wound Infections- Los Angeles County Jail

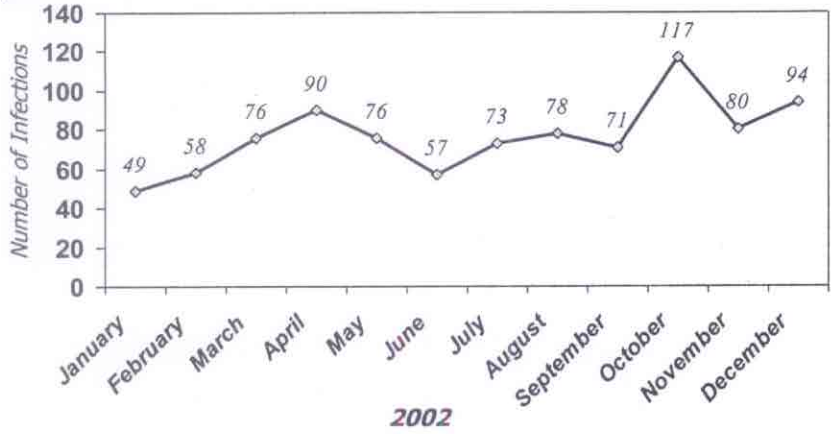


Figure 1

Number of Hospitalized Inmates with MRSA on Jail Ward at LAC-USC 1998-2002

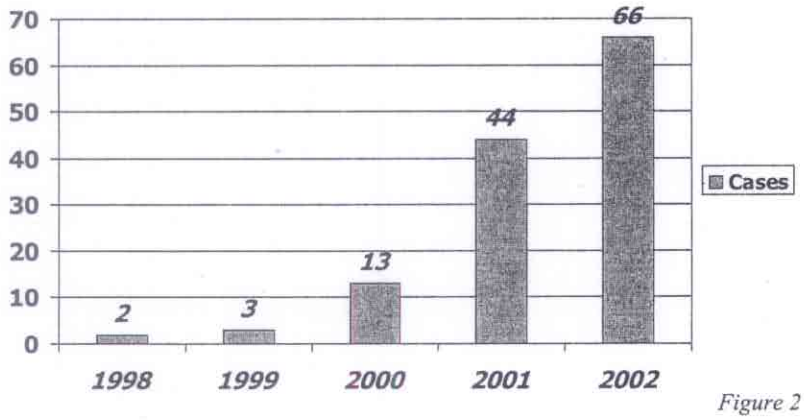


Figure 2

Public Health Recommendations for the Control of MRSA in the Los Angeles County Jail
August 2002

Surveillance

- Ask about skin infections as part of medical intake at Inmate Reception Area.
- Initiate Active Surveillance with daily logs of skin infections at medical clinics.
- Culture all skin infections at initial clinic visit.
- Evaluate cellmates and close contacts of cases for MRSA.
- Clearly identify medical charts of inmates with MRSA infection or colonization.

Wound Care and Treatment

- All dressing should be changed by medical unit daily until lesion dry with no drainage.
- On weekends, inmate should change own dressing with provided supplies.
- Educate inmates and staff on infectivity of wet or soiled bandages.
- Develop protocol for bandage disposal.
- Insure that the correct antibiotics are used to treat skin infections.

Prevention of MRSA Transmission

- **Educate Inmates about:**
  - MRSA transmission
  - Personal hygiene (hand washing, soap usage)
  - Encourage inmates to seek early care for skin lesions.

- **Personal Hygiene**
  - Increase shower frequency to every day.
  - Ensure availability of soap & encourage use.

- **Environment**
  - Clean & disinfect cell or dorm of MRSA cases on day of diagnosis.

- **Laundry**
  - Upon diagnosis with MRSA, inmates should shower & linen/clothes changed.
  - High temperature should be used for washing and drying of linens.
  - Linens should be dry before returning to inmate
  - Increase frequency of linen/uniform/underwear changes.

- **Transfer Policies**
  - Limit inter-facility movement for inmates with open wounds.
  - Medical summary and treatment plan should be transferred with inmate.
  - Clearly identify MRSA colonization or infection on inmate's medical record.

- **Staff Education & Protection**
  - Use Standard Precautions in Medical Clinics.
  - Provide education on MRSA infection control.
  - Educate proper removal & disposal of gloves after working with MRSA cases.
  - Educate custody staff about proper hand washing after glove use.

THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

February 10, 2003

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

Jonathan E. Fielding, M.D., M.P.H.
Director of Public Health and Health Officer

SUBJECT: **SYPHILIS AMONG MEN WHO HAVE SEX WITH MEN**

On October 25, 2002, this Department provided the Board with an updated report on syphilis among men who have sex with men (MSM) and on additional efforts being taken to address the endemic level of infection in L.A. County. This is to provide you with an update on these efforts.

UPDATE ON CASES

Through November 30, reports of early syphilis cases (primary, secondary, and early latent) in 2002 continued to outpace cases in 2001, both among MSM, and overall. MSM cases in this period totaled 352, representing a 56 percent increase over MSM cases for all of 2001, and an 81 percent increase over MSM cases reported for the same period (through November) in 2001. In this period, MSM cases constituted 70 percent of the total 507 early syphilis cases reported to the County. At least 57 percent of MSM cases in 2002 were HIV-positive, comparable to the 55 percent that were HIV-positive (through November) in 2001.

Attachment I contains the latest available Early Syphilis Surveillance Summary, featuring both total County and MSM syphilis data through November 30, 2002.

CURRENT EFFORTS

The following activities, already in place, have continued:

STD Program screening in the K-11 Unit (a unit exclusively housing MSM) in the Men's Central Jail. In 2002, through November, screening in K-11 resulted in 725 syphilis tests,

identifying 2 cases of secondary syphilis, 4 cases of early latent syphilis, and 1 case of late syphilis. In the same period, 807 HIV tests were given, with 65 positive (8 percent prevalence). Screening has also been conducted among jail trustees. Through November 2002, 477 syphilis tests among Trustees yielded detection of no new cases.

STD Program screening in community venues using the Mobile Clinic Unit (a mobile van). The Mobile Clinic Unit generally conducts outreach in areas or venues where there is a reasonable expectation of serving a substantial number of MSM clients. In 2002, the Unit averaged approximately 7 outreaches per month, during which it provided 1,512 syphilis tests. Of these, 50 were positive, leading to identification of 9 confirmed untreated cases (7 early and 2 late syphilis).

Screening by Adult Industry Medical in collaboration with the STD program at four commercial sex venues. In 2002, 363 individuals were screened, resulting in detection of 3 cases (0.8 percent) of early syphilis.

The HIV Epidemiology Program unlinked testing in two bathhouses. For the HIV Incidence Study in Commercial Sex Venues, HIV Epidemiology conducted screening at two bathhouses in 2002, one through July, and one through December. Altogether, in 2002, a total of 514 syphilis tests were provided at the two venues, of which 15 showed evidence of new or untreated infection. A total of 637 HIV tests were also conducted, 73 (11 percent) were positive for HIV.

In September though December 2002, STD Program worked with AIDS Healthcare Foundation (AHF) to pilot joint syphilis and HIV testing on the AHF mobile van, with a total of 3 joint outreaches conducted. The procedures established through this collaboration helped AHF to continue offering integrated services on its own, and provided a model for similar activities by other agencies.

A contract with AIDS Project Los Angeles (APLA) for $66,150 was approved by the Board on April 30, 2002, to provide a prevention advocate and liaison between the Department and the commercial sex venues (bathhouses and sex clubs). APLA also received an OAPP grant award for $150,000 to initiate, in collaboration with the STD Program, Childrens Hospital Los Angeles, and other agencies, a peer-to-peer program to promote safer sex norms in commercial sex venues. This program will adapt a Popular Opinion Leader (POL) model, used successfully for MSM population in other settings (e.g., bars) to commercial sex venues. Because of the complementary nature of these activities, APLA has created a special unit, the Commercial Sex Venue Initiative (CSVI) to conduct both projects. By October, 2002, CSVI had hired three staff. Eight commercial sex venues (six bath houses and two sex clubs) were selected as initial focus areas for the project. The unit has developed a needs assessment survey for use with commercial sex venue patrons, and has coordinated with the State STD Control Branch to obtain CSV data. The unit has also organized a coalition of community-based organizations that provide outreach and/or HIV/STD counseling and testing services in commercial sex venues, for the purpose of fostering collaboration and coordinating services. In the next two months, CSVI plans to develop outreach protocols and materials, implement a needs assessment and behavioral risk

assessment, recruit and provide training for Popular Opinion Leaders, convene community advisory board meetings, convene CSVI Coalition meetings, and hold a meeting with commercial sex venue owners/managers and L.A. County DHS representatives.

Ongoing efforts of the Latino Syphilis Working Group, a collaborative of four agencies serving Latino MSM, which originally formed at the end of 2001. The Working Group, co-facilitated by an STD Program staff member, has helped promote syphilis education outreaches by member agencies (both separately and jointly) targeting Latino MSM at key venues identified by the STD Program. Several monthly outreaches at a large gay Latino dance venue in Hollywood have been coordinated through Working Group collaborations. These educational outreaches focused on syphilis awareness and knowledge, in addition to HIV/AIDS and other STDs.

Los Angeles County Syphilis Morbidity reports have been distributed to physicians and other care providers serving high risk populations in the Los Angeles area. STD screening guidelines for sexually active HIV positive persons were developed and distributed as part of the Syphilis Morbidity report. An overview of the syphilis outbreak in Los Angeles County was summarized and published in *The Public's Heath,* a DHS newsletter, sent to 20,000 providers in the Los Angeles area. A risk assessment module was developed for HIV care providers at AHF, to be included in their computerized patient history acquisition. STD Program has also revised the Confidential Morbidity Report (CMR) cards to capture additional risk and partner data from care providers.

A contract to AIDS Healthcare Foundation (AHF) for $394,345 was approved by the Board on April 30, 2002, to coordinate and implement a targeted prevention media campaign directed at MSM. AHF coordinates this campaign in conjunction with 5 other MSM-serving community agencies, who have formally convened as the Syphilis Media Organizing Committee (SMOC), coordinated by AHF. The campaign known as "Stop the Sores," featuring a cartoon format and a primary character of a syphilis sore named "Phil," was launched June 20, 2002. To date, campaign activities have included.

34 English and 12 Spanish print ads in 4 English and 2 Spanish publications (all 6 publications used for the campaign target MSM, except the L.A. Weekly).

One English and one Spanish billboard (each 14' x 48') in West Hollywood and Hollywood locations.

A mobile billboard (English on one side, Spanish on the other) was used during the week of Christopher Street West (6/21 – 6/27).

A campaign website (www.stopthesores.org), linked to the STD Program website was also established to feature campaign materials, information about syphilis, and locations of testing resources.

Outreaches at Christopher Street West, Outfest, the Lotus Festival, Sunset Junction, Latin Pride, and specific venues and mobile test sites. At these events through December 2002, AHF and at least five other community agencies worked to distribute approximately 12,350 palm cards, 26,550 "Phil, the Syphilis Sore" stress grips bearing the STD Hotline number and the campaign website. Many outreaches have also featured an AHF staff member in a life-size "Phil" costume.

Ninety posters featuring "Phil" have been distributed to key venues or at outreaches.

A brief segment featuring the Los Angeles County and San Francisco syphilis campaigns was issued on the national cable program "The Daily Show," on the Comedy Central cable network. This segment aired July 23, 2002, and remains available for viewing on the Comedy Central website.

In summary, despite increased efforts by both DHS and collaborating community organizations, the outbreak of syphilis in MSMs is not under control, despite a continued decrease among others at risk in the population.

Information from a variety of sources in Los Angeles and other jurisdictions suggests an increase in unsafe sex practice among segments of the MSM community. We are very concerned that the increase in unsafe sex could also be increasing the rate of HIV transmission among those with and without syphilis.

To bring endemic syphilis under control requires a more effective combined effort of public and community agencies. DHS will intensify efforts to get bathhouses to promote safer sex practices and cooperate with agencies providing syphilis and HIV screening. We will find new cases of syphilis and treat them and their sexual contacts to prevent ongoing transmission of infection. We will also develop a partnership with one or more cities to increase the number of health education messages and the availability of condoms at bars and other appropriate venues with a predominantly gay clientele.

Continued testing and treatment is another essential part of our continuing control efforts. Unfortunately testing to date around sex venues has yielded low recruitment and a low rate of positives. The STD program believes our low yield rate may reflect that our screening efforts are primarily attracting the "worried well" population rather than those at highest risk. We will continue to promote screening in the highest risk groups.

A central element of our control efforts must be a commitment by leaders of the gay community to provide leadership in helping to change behavioral norms so that individuals take greater responsibility for their own sexual behavior. Leadership from the community is essential to reverse the ominous trends in safe sex practices, particularly among those with diagnosed HIV infection.

Public Health will also establish an advisory group on gay/lesbian/trans-gender health issues, to help inform our strategies to improve population health. Further, we will continue to collaborate with the State, CDC and other municipalities to determine best practices in trying to control this outbreak.

We will provide you with another update in 90 days. In the meantime, it you have any questions or need additional information, please let either of us know.

TLG:jh
003:024

Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

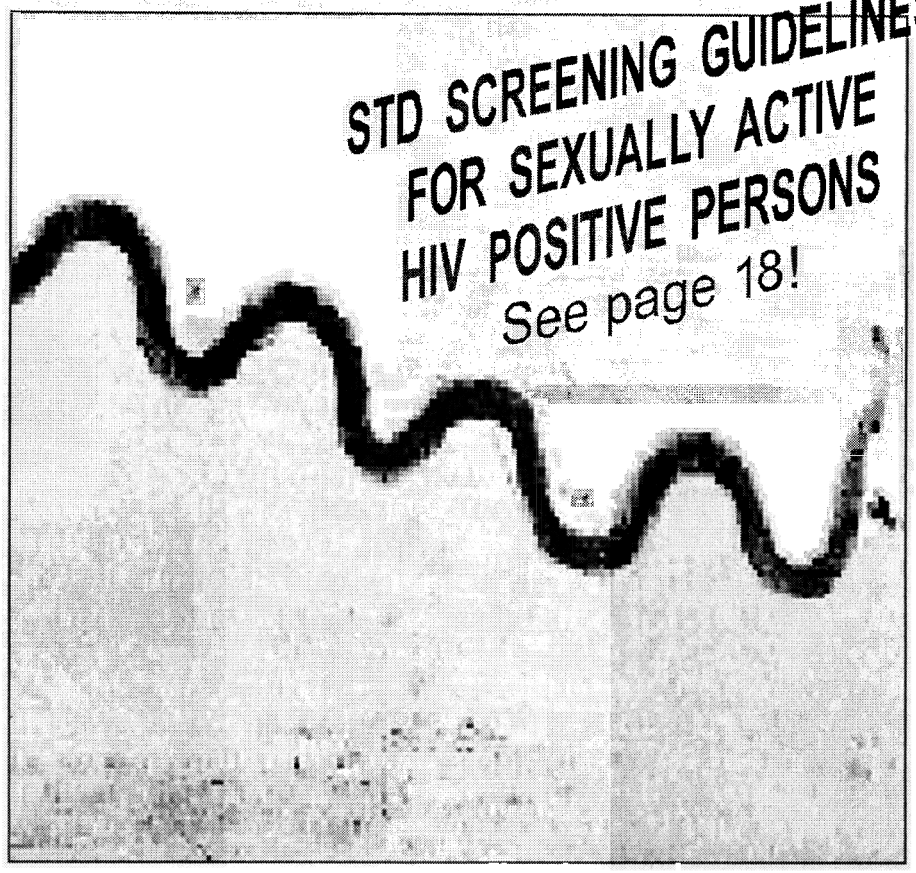
Attachment I

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

SEXUALLY TRANSMITTED DISEASE PROGRAM

Early Syphilis Surveillance Summary

Cases reported as of November 30, 2002
Issued December 15, 2002



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www.lapublichealth.org/std

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

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www.lapublichealth.org

December 15, 2002

Dear Colleague,

We are pleased to release the December 2002 *Early Syphilis Surveillance Summary* for Los Angeles County. In the first eleven months of this year, 507 early syphilis cases have been reported; 109, or 27 percent more than in 2001 (N=398).

The ongoing outbreak of syphilis has primarily affected men who report having sex with other men (MSM) and is concentrated in Service Planning Area 4 (Metro) and the Hollywood-Wilshire Health District. Approximately 6 in 10 MSM *with syphilis* also report being infected with HIV.

Due to the high risk of HIV transmission when co-infected with other STDs, we are recommending specific STD screening guidelines for *sexually active HIV positive* patients. These recommended guidelines are provided in Appendix D on page 18 of this report. We urge you to review these recommended guidelines and implement them for all sexually active HIV infected patients.

If you would like to receive reports, guidelines, or other information from the STD Program as it becomes available, please visit **http://ladhs.org/listserv** and register for **STDInfo** or call the STD Program at (213) 744-3070 and provide the attendant with your e-mail address.

Sincerely,

Peter R. Kerndt, MD, MPH
Director, Sexually Transmitted Disease Program

Thomas L. Garthwaite, MD
Director, Health Services & Chief Medical Officer

Jonathan E. Fielding, MD, MPH
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The *Early Syphilis Surveillance Summary* is published on a monthly basis by the Sexually Transmitted Disease Program of the Los Angeles County Department of Health Services. This report is also available in PDF format, online at **www.lapublichealth.org/std.**

If you would like to receive surveillance reports and other information from the STD Program, please call (213) 744-3070 and provide the attendant with your email address or register for ***STDInfo*** online at **http://ladhs.org/listserv**.

SUGGESTED CITATION

Sexually Transmitted Disease Program, Los Angeles County Department of Health Services. *Early Syphilis Surveillance Summary, December 2002.* pp. 1-18.

FRONT COVER: Treponema pallidum (Syphilis spirochete)

CONTENTS

Early Syphilis Surveillance Summary, Los Angeles County as of November 30, 2002

Table 1. Early Syphilis - All Cases	2002 (YTD)				2001 (YTD)				2001				2000			
	P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES	
	N	N	N	%	N	N	N	%	N	N	N	%	N	N	N	%
Morbidity																
Total	264	243	507	(100.0)	166	181	347	(100.0)	189	209	398	(100.0)	137	200	337	(100.0)
Gender																
Male	249	212	461	(90.9)	156	134	290	(83.5)	178	156	334	(83.9)	110	122	232	(68.8)
Female	15	31	46	(9.0)	9	47	56	(16.1)	9	52	61	(15.3)	23	74	97	(28.7)
Transgender:M to F	.	.	.	(0.0)	1	.	1	(0.2)	2	1	3	(0.7)	4	4	8	(2.3)
Sexual Orientation [1]																
MSM	181	142	323	(63.7)	110	71	181	(52.1)	124	84	208	(52.2)	60	46	106	(31.4)
MSM/W	21	8	29	(5.7)	9	3	12	(3.4)	10	4	14	(3.5)	7	5	12	(3.5)
MSW	20	37	57	(11.2)	24	35	59	(17.0)	29	41	70	(17.5)	35	61	96	(28.4)
WSM	12	24	36	(7.1)	8	40	48	(13.8)	8	44	52	(13.0)	20	68	88	(26.1)
WSW	.	.	.	(0.0)	.	2	2	(0.5)	.	2	2	(0.5)	.	1	1	(0.2)
WSW/M	.	.	.	(0.0)	.	1	1	(0.2)	.	1	1	(0.2)	1	1	2	(0.5)
TG/STG	.	.	.	(0.0)	1	.	1	(0.2)	2	1	3	(0.7)	4	4	8	(2.3)
Refused	2	1	3	(0.5)	3	6	9	(2.5)	4	6	10	(2.5)	5	3	8	(2.3)
Unknown	28	31	59	(11.6)	11	23	34	(9.7)	12	26	38	(9.5)	5	11	16	(4.7)
HIV Positive [2]																
Yes	120	97	217	(42.8)	63	53	116	(33.4)	71	64	135	(33.9)	.	.	.	(0.0)
No	87	83	170	(33.5)	57	64	121	(34.8)	63	70	133	(33.4)	.	.	.	(0.0)
Unknown	57	63	120	(23.6)	46	64	110	(31.7)	55	75	130	(32.6)	137	200	337	(100.0)
Race/Ethnicity																
White	113	69	182	(35.8)	62	34	96	(27.6)	67	40	107	(26.8)	41	22	63	(18.6)
Afr.-Amer.	40	34	74	(14.5)	32	24	56	(16.1)	37	29	66	(16.5)	32	33	65	(19.2)
Latina/o	86	122	208	(41.0)	63	110	173	(49.8)	76	125	201	(50.5)	59	135	194	(57.5)
Asian/Pac. Is.	13	8	21	(4.1)	6	4	10	(2.8)	6	5	11	(2.7)	2	8	10	(2.9)
Am.Ind/Alas.Nat.	1	2	3	(0.5)	.	1	1	(0.2)	.	1	1	(0.2)	.	.	.	(0.0)
Other/Mixed	.	1	1	(0.1)	1	.	1	(0.2)	1	.	1	(0.2)	.	.	.	(0.0)
Unknown	11	7	18	(3.5)	2	8	10	(2.8)	2	9	11	(2.7)	3	2	5	(1.4)
Age Group																
<15	1	.	1	(0.1)	.	3	3	(0.8)	.	3	3	(0.7)	.	1	1	(0.2)
15-19	3	11	14	(2.7)	5	6	11	(3.1)	7	7	14	(3.5)	2	9	11	(3.2)
20-24	21	36	57	(11.2)	15	13	28	(8.0)	19	15	34	(8.5)	10	32	42	(12.4)
25-29	29	25	54	(10.6)	25	24	49	(14.1)	26	31	57	(14.3)	18	39	57	(16.9)
30-34	48	52	100	(19.7)	36	44	80	(23.0)	40	51	91	(22.8)	31	36	67	(19.8)
35-39	63	47	110	(21.6)	40	47	87	(25.0)	46	52	98	(24.6)	30	33	63	(18.6)
40-44	48	41	89	(17.5)	21	19	40	(11.5)	26	23	49	(12.3)	20	23	43	(12.7)
45-49	28	14	42	(8.2)	16	12	28	(8.0)	17	13	30	(7.5)	12	16	28	(8.3)
50-54	13	10	23	(4.5)	6	5	11	(3.1)	6	6	12	(3.0)	9	8	17	(5.0)
55-59	4	5	9	(1.7)	1	6	7	(2.0)	1	6	7	(1.7)	2	3	5	(1.4)
60 +	6	2	8	(1.5)	1	2	3	(0.8)	1	2	3	(0.7)	3	.	3	(0.8)

[1] Note: MSM refers to men who have sex with men; MSM/W is men who have sex with men and women; MSW is men who have sex with women; WSM refers to women who have sex with men; WSW is women who have sex with women; WSW/M is women who have sex with women and men. TG/STG refers to male-to-female (M to F) transgenders or to men or women who have sex with M to F transgenders.

[2] HIV Status for 2000 is not yet available for this report.

Table 2.
Early Syphilis - SPA and Health District of Residence

		2002 (YTD)				2001				2000			
		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES	
		N	N	N	%	N	N	N	%	N	N	N	%
SPA	**District**												
SPA 1 - ANTELOPE VALLEY	Antelope Valley	2	1	3	(0.5)	1	.	1	(0.2)	2	2	4	(1.1)
	SPA Total	2	1	3	(0.5)	1	.	1	(0.2)	2	2	4	(1.1)
SPA 2 - SAN FERNANDO VALLEY	**District**												
	East Valley	9	10	19	(3.7)	11	7	18	(4.5)	4	6	10	(2.9)
	Glendale	6	7	13	(2.5)	3	5	8	(2.0)	.	3	3	(0.8)
	San Fernando	5	5	10	(1.9)	2	4	6	(1.5)	.	1	1	(0.2)
	West Valley	8	10	18	(3.5)	9	7	16	(4.0)	7	8	15	(4.4)
	SPA Total	28	32	60	(11.8)	25	23	48	(12.0)	11	18	29	(8.6)
SPA 3 - SAN GABRIEL	**District**												
	Alhambra	2	2	4	(0.7)	1	2	3	(0.7)	.	.	.	.
	El Monte	3	4	7	(1.3)	4	9	13	(3.2)	2	10	12	(3.5)
	Foothill	1	.	1	(0.1)	2	1	3	(0.7)	2	2	4	(1.1)
	Pomona	4	6	10	(1.9)	5	10	15	(3.7)	6	9	15	(4.4)
	SPA Total	10	12	22	(4.3)	12	22	34	(8.5)	10	21	31	(9.1)
SPA 4 - METRO	**District**												
	Central	28	44	72	(14.2)	24	28	52	(13.0)	18	19	37	(10.9)
	Northeast	8	10	18	(3.5)	13	11	24	(6.0)	5	18	23	(6.8)
	Hollywood-Wilshire	112	71	183	(36.0)	50	46	96	(24.1)	37	32	69	(20.4)
	SPA Total	148	125	273	(53.8)	87	85	172	(43.2)	60	69	129	(38.2)
SPA 5 - WEST	**District**												
	West	22	10	32	(6.3)	12	6	18	(4.5)	4	3	7	(2.0)
	SPA Total	22	10	32	(6.3)	12	6	18	(4.5)	4	3	7	(2.0)
SPA 6 - SOUTH	**District**												
	Compton	4	5	9	(1.7)	5	10	15	(3.7)	3	16	19	(5.6)
	South	3	5	8	(1.5)	1	3	4	(1.0)	7	9	16	(4.7)
	Southeast	4	4	8	(1.5)	7	5	12	(3.0)	2	10	12	(3.5)
	Southwest	9	9	18	(3.5)	11	13	24	(6.0)	7	12	19	(5.6)
	SPA Total	20	23	43	(8.4)	24	31	55	(13.8)	19	47	66	(19.5)
SPA 7 - EAST	**District**												
	East Los Angeles	2	.	2	(0.3)	4	5	9	(2.2)	2	8	10	(2.9)
	Whittier	1	9	10	(1.9)	5	2	7	(1.7)	2	4	6	(1.7)
	Bellflower	6	3	9	(1.7)	3	8	11	(2.7)	2	4	6	(1.7)
	San Antonio	6	5	11	(2.1)	3	11	14	(3.5)	6	12	18	(5.3)
	SPA Total	15	17	32	(6.3)	15	26	41	(10.3)	12	28	40	(11.8)
SPA 8 - SOUTH BAY	**District**												
	Harbor	3	9	12	(2.3)	1	1	2	(0.5)	3	3	6	(1.7)
	Inglewood	7	10	17	(3.3)	7	7	14	(3.5)	11	3	14	(4.1)
	Torrance	7	2	9	(1.7)	4	3	7	(1.7)	3	2	5	(1.4)
	SPA Total	17	21	38	(7.4)	12	11	23	(5.7)	17	8	25	(7.4)
UNKNOWN SPA	**District**												
	UNKNOWN	2	2	4	(0.7)	1	5	6	(1.5)	2	4	6	(1.7)
	SPA Total	2	2	4	(0.7)	1	5	6	(1.5)	2	4	6	(1.7)

Table 3. MSM[1] General Demographics	2002 (YTD)				2001 (YTD)				2001				2000			
	P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES	
	N	N	N	%	N	N	N	%	N	N	N	%	N	N	N	%
Morbidity																
Total	202	150	352	(100.0)	120	74	194	(100.0)	136	89	225	(100.0)	71	55	126	(100.0)
Sexual Orientation																
MSM	181	142	323	(91.7)	110	71	181	(93.2)	124	84	208	(92.4)	60	46	106	(84.1)
MSM/W	21	8	29	(8.2)	9	3	12	(6.1)	10	4	14	(6.2)	7	5	12	(9.5)
TG/STG	.	.	.	(0.0)	1	.	1	(0.5)	2	1	3	(1.3)	4	4	8	(6.3)
HIV Positive[2]																
Yes	111	89	200	(56.8)	62	44	106	(54.6)	70	53	123	(54.6)	.	.	.	(0.0)
No	65	36	101	(28.6)	36	16	52	(26.8)	39	17	56	(24.8)	.	.	.	(0.0)
Unknown	26	25	51	(14.4)	22	14	36	(18.5)	27	19	46	(20.4)	71	55	126	(100.0)
Race/Ethnicity																
White	96	59	155	(44.0)	54	20	74	(38.1)	58	25	83	(36.8)	30	13	43	(34.1)
Afr.-Amer.	25	13	38	(10.7)	18	5	23	(11.8)	20	8	28	(12.4)	9	8	17	(13.4)
Latina/o	63	66	129	(36.6)	42	42	84	(43.2)	52	47	99	(44.0)	30	33	63	(50.0)
Asian/Pac. Is.	10	6	16	(4.5)	5	3	8	(4.1)	5	4	9	(4.0)	1	1	2	(1.5)
Am.Ind/Alas.Nat.	1	1	2	(0.5)	.	1	1	(0.5)	.	1	1	(0.4)	.	.	.	(0.0)
Other/Mixed	.	.	.	(0.0)	1	.	1	(0.5)	1	.	1	(0.4)	.	.	.	(0.0)
Unknown	7	5	12	(3.4)	.	3	3	(1.5)	.	4	4	(1.7)	1	.	1	(0.7)
Age Group																
<15	1	.	1	(0.2)	.	.	.	(0.0)	.	.	.	(0.0)	.	.	.	(0.0)
15-19	2	3	5	(1.4)	3	1	4	(2.0)	4	1	5	(2.2)	.	.	.	(0.0)
20-24	13	16	29	(8.2)	10	4	14	(7.2)	13	5	18	(8.0)	4	5	9	(7.1)
25-29	25	12	37	(10.5)	20	10	30	(15.4)	21	14	35	(15.5)	7	11	18	(14.2)
30-34	38	39	77	(21.8)	24	18	42	(21.6)	26	22	48	(21.3)	19	13	32	(25.3)
35-39	50	29	79	(22.4)	34	18	52	(26.8)	37	23	60	(26.6)	21	15	36	(28.5)
40-44	40	31	71	(20.1)	15	13	28	(14.4)	20	14	34	(15.1)	12	6	18	(14.2)
45-49	21	9	30	(8.5)	8	4	12	(6.1)	9	4	13	(5.7)	6	3	9	(7.1)
50-54	6	8	14	(3.9)	5	2	7	(3.6)	5	2	7	(3.1)	2	2	4	(3.1)
55-59	3	3	6	(1.7)	1	3	4	(2.0)	1	3	4	(1.7)	.	.	.	(0.0)
60 +	3	.	3	(0.8)	.	1	1	(0.5)	.	1	1	(0.4)	.	.	.	(0.0)

[1] MSM includes gay and bisexual men, M to F transgenders, and men who have sex with M to F transgenders

[2] HIV Status for 2000 is not yet available for this report.

Table 4. General Demographics - Female	2002 (YTD)				2001 (YTD)				2001				2000			
	P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES	
	N	N	N	%	N	N	N	%	N	N	N	%	N	N	N	%
Morbidity																
Total	15	31	46	(100.0)	9	47	56	(100.0)	9	52	61	(100.0)	23	74	97	(100.0)
Sexual Orientation																
WSM	12	24	36	(78.2)	8	40	48	(85.7)	8	44	52	(85.2)	20	68	88	(90.7)
WSW	.	.	.	(0.0)	.	2	2	(3.5)	.	2	2	(3.2)	.	1	1	(1.0)
WSWIM	.	.	.	(0.0)	.	1	1	(1.7)	.	1	1	(1.6)	1	1	2	(2.0)
Unknown	3	7	10	(21.7)	1	4	5	(8.9)	1	5	6	(9.8)	2	4	6	(6.1)
HIV Positive[1]																
Yes	.	1	1	(2.1)	.	2	2	(3.5)	.	2	2	(3.2)	.	.	.	(0.0)
No	9	19	28	(60.8)	4	23	27	(48.2)	4	26	30	(49.1)	.	.	.	(0.0)
Unknown	6	11	17	(36.9)	5	22	27	(48.2)	5	24	29	(47.5)	23	74	97	(100.0)
Race/Ethnicity																
White	.	3	3	(6.5)	2	4	6	(10.7)	2	4	6	(9.8)	1	6	7	(7.2)
Afr.-Amer.	8	6	14	(30.4)	3	9	12	(21.4)	3	10	13	(21.3)	10	14	24	(24.7)
Latina/o	6	21	27	(58.6)	4	33	37	(66.0)	4	37	41	(67.2)	10	51	61	(62.8)
Asian/Pac. Is.	.	.	.	(0.0)	.	.	.	(0.0)	.	.	.	(0.0)	.	2	2	(2.0)
Am.Ind/Alas.Nat.	.	1	1	(2.1)	.	.	.	(0.0)	.	.	.	(0.0)	.	.	.	(0.0)
Unknown	1	.	1	(2.1)	.	1	1	(1.7)	.	1	1	(1.6)	2	1	3	(3.0)
Age Group																
<15	.	.	.	(0.0)	.	3	3	(5.3)	.	3	3	(4.9)	.	1	1	(1.0)
15-19	.	3	3	(6.5)	1	4	5	(8.9)	1	5	6	(9.8)	1	6	7	(7.2)
20-24	3	11	14	(30.4)	1	6	7	(12.5)	1	7	8	(13.1)	4	20	24	(24.7)
25-29	.	3	3	(6.5)	2	5	7	(12.5)	2	6	8	(13.1)	4	19	23	(23.7)
30-34	3	4	7	(15.2)	1	11	12	(21.4)	1	12	13	(21.3)	5	8	13	(13.4)
35-39	4	4	8	(17.3)	.	11	11	(19.6)	.	11	11	(18.0)	1	8	9	(9.2)
40-44	.	2	2	(4.3)	1	2	3	(5.3)	1	3	4	(6.5)	2	5	7	(7.2)
45-49	3	2	5	(10.8)	3	4	7	(12.5)	3	4	7	(11.4)	2	5	7	(7.2)
50-54	2	.	2	(4.3)	.	1	1	(1.7)	.	1	1	(1.6)	2	1	3	(3.0)
55-59	.	1	1	(2.1)	.	.	.	(0.0)	.	.	.	(0.0)	1	1	2	(2.0)
60 +	.	1	1	(2.1)	.	.	.	(0.0)	.	.	.	(0.0)	1	.	1	(1.0)
Prenatal/Pregnant																
YES	.	1	1	(2.1)	1	4	5	(8.9)	1	4	5	(8.1)	.	.	.	(0.0)
NO	11	14	25	(54.3)	.	10	10	(17.8)	.	11	11	(18.0)	.	.	.	(0.0)
UNKNOWN	4	16	20	(43.4)	8	33	41	(73.2)	8	37	45	(73.7)	23	74	97	(100.0)

[1] HIV Status for 2000 is not yet available for this report.

Table 5. General Demographics - Heterosexual Men[1]	2002 (YTD)				2001 (YTD)				2001				2000			
	P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES		P&S	Early Latent	Total ES	
	N	N	N	%	N	N	N	%	N	N	N	%	N	N	N	%
Morbidity																
Total	20	37	57	(100.0)	24	35	59	(100.0)	29	41	70	(100.0)	35	61	96	(100.0)
Sexual Orientation																
MSW	20	37	57	(100.0)	24	35	59	(100.0)	29	41	70	(100.0)	35	61	96	(100.0)
HIV Positive[1,2]																
Yes	4	1	5	(8.7)	.	1	1	(1.6)	.	3	3	(4.2)	.	.	.	(0.0)
No	11	26	37	(64.9)	16	25	41	(69.4)	19	27	46	(65.7)	.	.	.	(0.0)
Unknown	5	10	15	(26.3)	8	9	17	(28.8)	10	11	21	(30.0)	35	61	96	(100.0)
Race/Ethnicity																
White	4	2	6	(10.5)	3	4	7	(11.8)	4	4	8	(11.4)	6	3	9	(9.3)
Afr.-Amer.	5	10	15	(26.3)	6	4	10	(16.9)	7	5	12	(17.1)	10	8	18	(18.7)
Latino	8	24	32	(56.1)	14	26	40	(67.7)	17	31	48	(68.5)	18	44	62	(64.5)
Asian/Pac. Is.	2	1	3	(5.2)	1	1	2	(3.3)	1	1	2	(2.8)	1	5	6	(6.2)
Unknown	1	.	1	(1.7)	.	.	.	(0.0)	.	.	.	(0.0)	.	1	1	(1.0)
Age Group																
15-19	1	5	6	(10.5)	1	1	2	(3.3)	2	1	3	(4.2)	1	3	4	(4.1)
20-24	3	6	9	(15.7)	3	3	6	(10.1)	4	3	7	(10.0)	2	6	8	(8.3)
25-29	2	7	9	(15.7)	2	7	9	(15.2)	2	8	10	(14.2)	5	8	13	(13.5)
30-34	3	4	7	(12.2)	6	8	14	(23.7)	8	9	17	(24.2)	4	13	17	(17.7)
35-39	4	8	12	(21.0)	4	8	12	(20.3)	5	8	13	(18.5)	7	8	15	(15.6)
40-44	1	4	5	(8.7)	2	2	4	(6.7)	2	4	6	(8.5)	5	10	15	(15.6)
45-49	1	1	2	(3.5)	5	3	8	(13.5)	5	4	9	(12.8)	4	6	10	(10.4)
50-54	3	.	3	(5.2)	1	1	2	(3.3)	1	2	3	(4.2)	4	5	9	(9.3)
55-59	1	1	2	(3.5)	.	1	1	(1.6)	.	1	1	(1.4)	1	2	3	(3.1)
60 +	1	1	2	(3.5)	.	1	1	(1.6)	.	1	1	(1.4)	2	.	2	(2.0)

[1] Heterosexual men are male cases who did not report having male or M to F transgender sex partners.
[2] HIV Status for 2000 is not yet available for this report.

Table 6. Behavioral Risk Factors by Sexual Orientation[1]	2002 (YTD)						2001					
	MSM & MSM/W		MSW		All Female		MSM & MSM/W		MSW		All Female	
	N	%	N	%	N	%	N	%	N	%	N	%
Anal Insertive												
Yes	208	(72.2)	3	(6.3)	.	(0.0)	149	(67.4)	4	(5.7)	.	(0.0)
No	37	(12.8)	32	(68.0)	20	(66.6)	20	(9.0)	20	(28.5)	20	(38.4)
Unknown	43	(14.9)	12	(25.5)	10	(33.3)	52	(23.5)	46	(65.7)	32	(61.5)
Anal Receptive												
Yes	201	(69.7)	.	(0.0)	6	(20.0)	143	(64.7)	1	(1.4)	3	(5.7)
No	43	(14.9)	33	(70.2)	17	(56.6)	26	(11.7)	22	(31.4)	15	(28.8)
Unknown	44	(15.2)	14	(29.7)	7	(23.3)	52	(23.5)	47	(67.1)	34	(65.3)
Oral Sex												
Yes	238	(82.6)	21	(44.6)	12	(40.0)	170	(76.9)	32	(45.7)	23	(44.2)
No	12	(4.1)	13	(27.6)	11	(36.6)	6	(2.7)	9	(12.8)	5	(9.6)
Unknown	38	(13.1)	13	(27.6)	7	(23.3)	45	(20.3)	29	(41.4)	24	(46.1)
Vaginal Sex												
Yes	26	(9.0)	44	(93.6)	26	(86.6)	8	(3.6)	62	(88.5)	43	(82.6)
No	220	(76.3)	2	(4.2)	.	(0.0)	90	(40.7)	.	(0.0)	1	(1.9)
Unknown	42	(14.5)	1	(2.1)	4	(13.3)	123	(55.6)	8	(11.4)	8	(15.3)
Anonymous Partners												
Yes	186	(64.5)	18	(38.2)	2	(6.6)	123	(55.6)	22	(31.4)	6	(11.5)
No	58	(20.1)	20	(42.5)	21	(70.0)	42	(19.0)	21	(30.0)	24	(46.1)
Unknown	44	(15.2)	9	(19.1)	7	(23.3)	56	(25.3)	27	(38.5)	22	(42.3)
Condom Used[2]												
Yes	70	(24.3)	13	(27.6)	5	(16.6)	63	(28.5)	19	(27.1)	11	(21.1)
No	153	(53.1)	23	(48.9)	20	(66.6)	78	(35.2)	28	(40.0)	19	(36.5)
Unknown	65	(22.5)	11	(23.4)	5	(16.6)	80	(36.1)	23	(32.8)	22	(42.3)
Incarcerated Past Year												
Yes	6	(2.0)	6	(12.7)	.	(0.0)	10	(4.5)	3	(4.2)	3	(5.7)
No	187	(64.9)	21	(44.6)	13	(43.3)	131	(59.2)	36	(51.4)	25	(48.0)
Unknown	95	(32.9)	20	(42.5)	17	(56.6)	80	(36.1)	31	(44.2)	24	(46.1)
IV Drug User												
Yes	8	(2.7)	.	(0.0)	.	(0.0)	3	(1.3)	3	(4.2)	1	(1.9)
No	235	(81.5)	44	(93.6)	25	(83.3)	176	(79.6)	50	(71.4)	34	(65.3)
Unknown	45	(15.6)	3	(6.3)	5	(16.6)	42	(19.0)	17	(24.2)	17	(32.6)
Non-IV Drug User												
Yes	61	(21.1)	12	(25.5)	3	(10.0)	53	(23.9)	20	(28.5)	5	(9.6)
No	178	(61.8)	30	(63.8)	21	(70.0)	123	(55.6)	28	(40.0)	29	(55.7)
Unknown	49	(17.0)	5	(10.6)	6	(20.0)	45	(20.3)	22	(31.4)	18	(34.6)

[1] Behavioral risk information is available starting in 2001 and includes closed cases only. Does not include cases with no information on sexual partners.
[2] Condom was used at last intercourse

Table 7. Venue Risk by Sexual Orientation[1]	2002 (YTD)						2001					
	MSM & MSM/W		MSW		All Female		MSM & MSM/W		MSW		All Female	
	N	%	N	%	N	%	N	%	N	%	N	%
Bars and Clubs												
Yes	96	(33.3)	12	(25.5)	3	(10.0)	104	(47.0)	18	(25.7)	4	(7.6)
No	129	(44.7)	27	(57.4)	20	(66.6)	37	(16.7)	14	(20.0)	16	(30.7)
Unknown	63	(21.8)	8	(17.0)	7	(23.3)	80	(36.1)	38	(54.2)	32	(61.5)
Bathhouses/ Sex Clubs												
Yes	63	(21.8)	.	(0.0)	.	(0.0)	31	(14.0)	.	(0.0)	.	(0.0)
No	148	(51.3)	34	(72.3)	22	(73.3)	77	(34.8)	20	(28.5)	16	(30.7)
Unknown	77	(26.7)	13	(27.6)	8	(26.6)	113	(51.1)	50	(71.4)	36	(69.2)
Motels												
Yes	7	(2.4)	2	(4.2)	1	(3.3)	4	(1.8)	4	(5.7)	3	(5.7)
No	193	(67.0)	31	(65.9)	21	(70.0)	86	(38.9)	18	(25.7)	14	(26.9)
Unknown	88	(30.5)	14	(29.7)	8	(26.6)	131	(59.2)	48	(68.5)	35	(67.3)
Streets												
Yes	16	(5.5)	11	(23.4)	1	(3.3)	10	(4.5)	2	(2.8)	4	(7.6)
No	189	(65.6)	25	(53.1)	21	(70.0)	83	(37.5)	20	(28.5)	13	(25.0)
Unknown	83	(28.8)	11	(23.4)	8	(26.6)	128	(57.9)	48	(68.5)	35	(67.3)
Internet												
Yes	42	(14.5)	.	(0.0)	.	(0.0)	17	(7.6)	1	(1.4)	.	(0.0)
No	164	(56.9)	34	(72.3)	22	(73.3)	78	(35.2)	20	(28.5)	16	(30.7)
Unknown	82	(28.4)	13	(27.6)	8	(26.6)	126	(57.0)	49	(70.0)	36	(69.2)
Parks												
Yes	16	(5.5)	1	(2.1)	.	(0.0)	14	(6.3)	.	(0.0)	.	(0.0)
No	185	(64.2)	33	(70.2)	22	(73.3)	82	(37.1)	20	(28.5)	16	(30.7)
Unknown	87	(30.2)	13	(27.6)	8	(26.6)	125	(56.5)	50	(71.4)	36	(69.2)
Other Venue												
Yes	51	(17.7)	6	(12.7)	2	(6.6)	39	(17.6)	7	(10.0)	1	(1.9)
No	145	(50.3)	23	(48.9)	21	(70.0)	72	(32.5)	19	(27.1)	15	(28.8)
Unknown	92	(31.9)	18	(38.2)	7	(23.3)	110	(49.7)	44	(62.8)	36	(69.2)
Total	288	(100.0)	47	(100.0)	30	(100.0)	221	(100.0)	70	(100.0)	52	(100.0)

[1] Had sex or met sex partners at defined venues during the period when syphilis infection likely occurred (critical period).
[2] Venue risk information is available starting in 2001 and includes closed cases only. Does not include cases with no information on sexual partners.

igu Primary Secon ary Syph by 'ear District of Residence [n= 590]

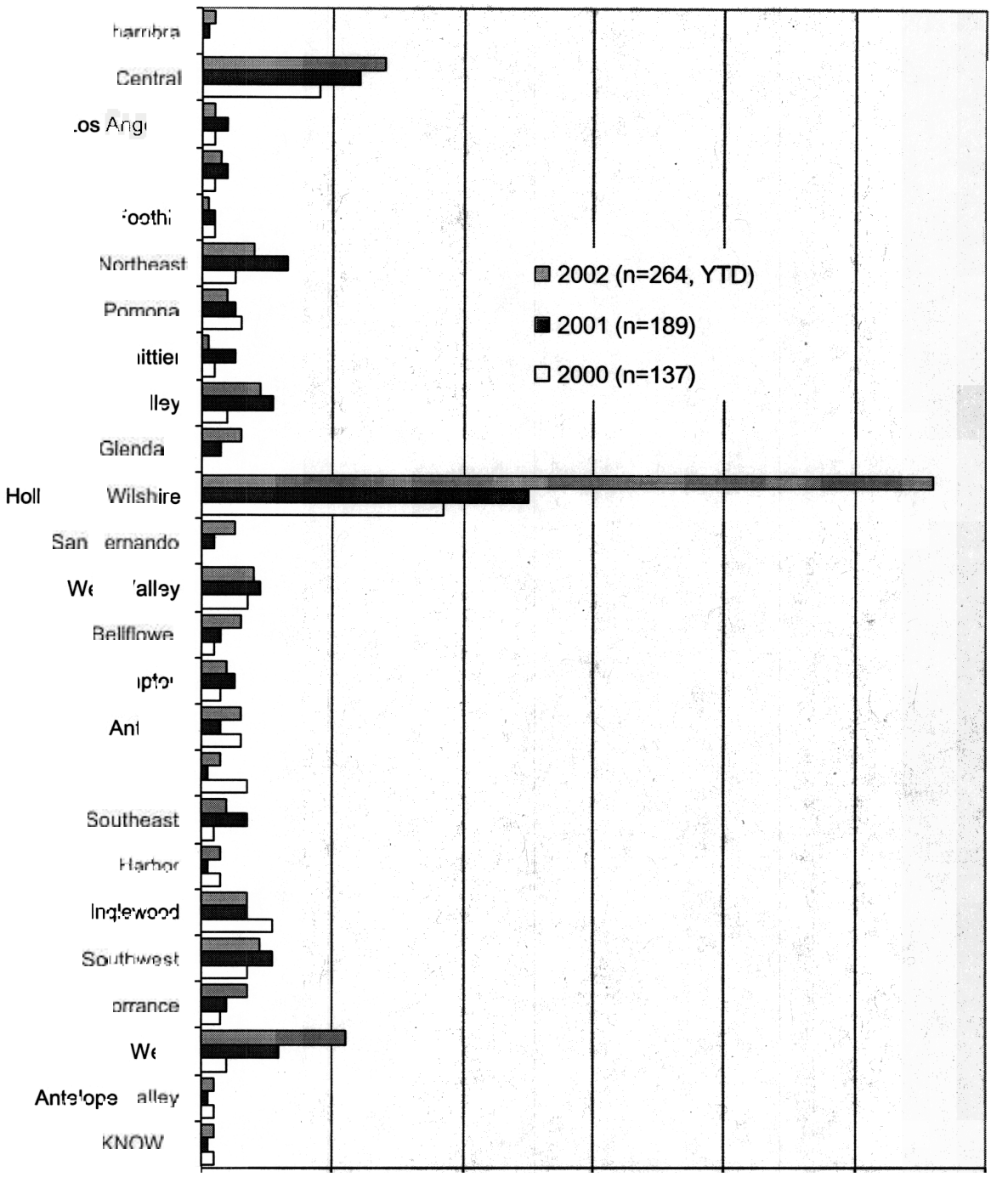


Figure 2: Primary & Secondary Syphilis by SPA 2001 (n=189)

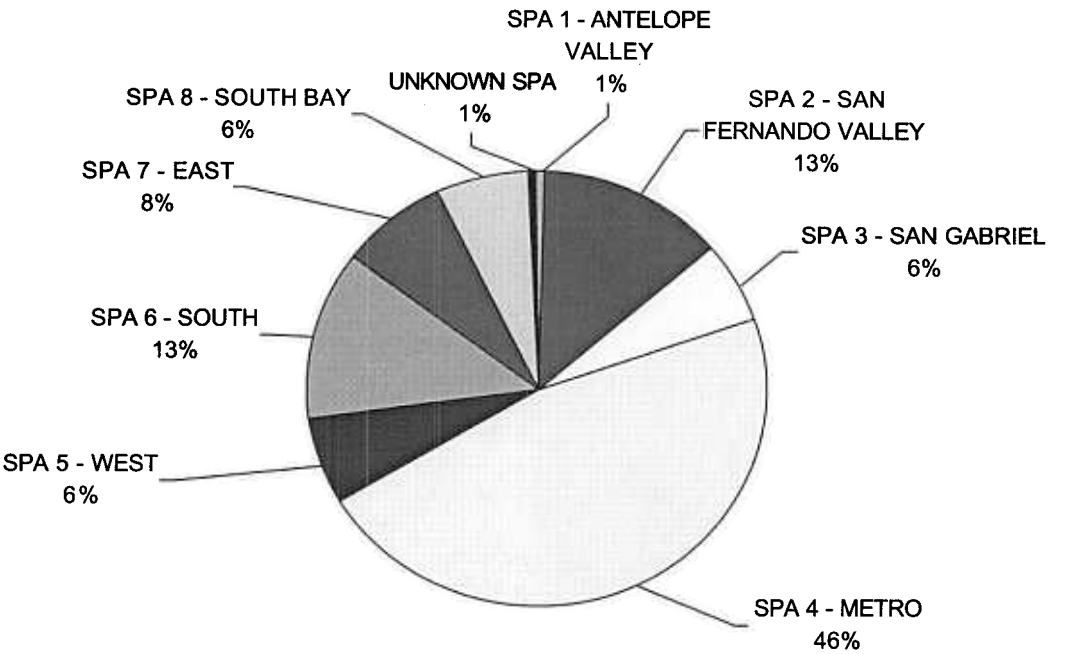


Figure 3: Primary & Secondary Syphilis by SPA, January Through November 2002 (n=264)

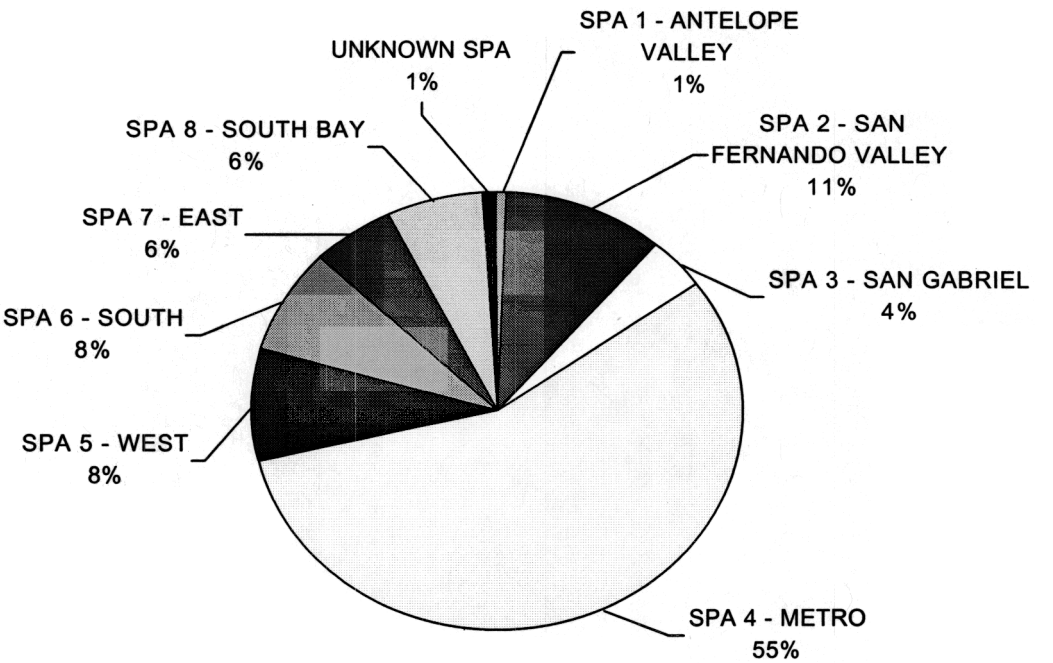
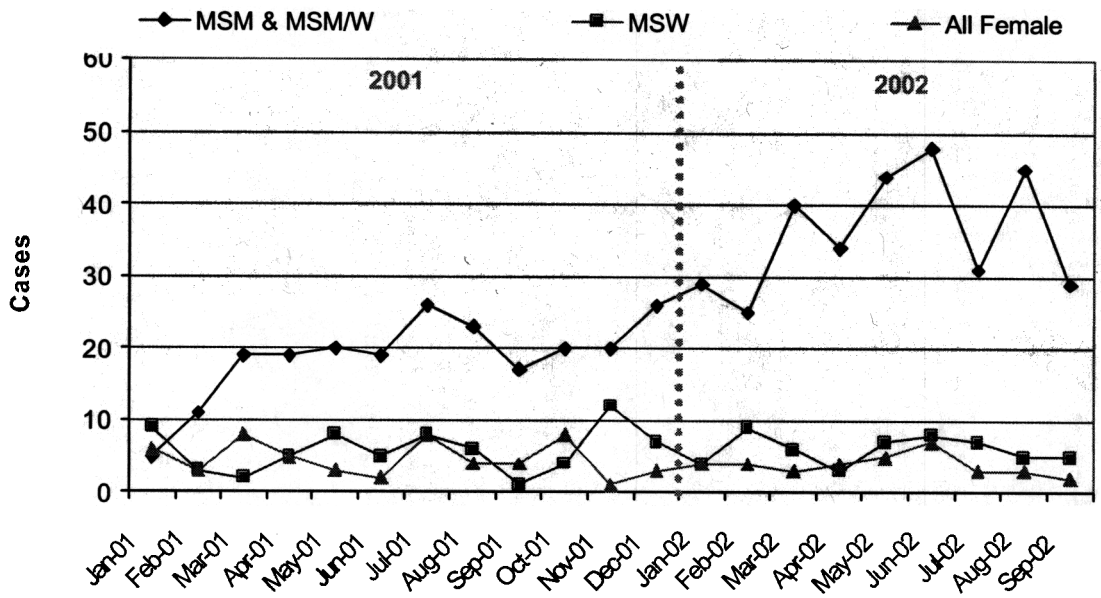
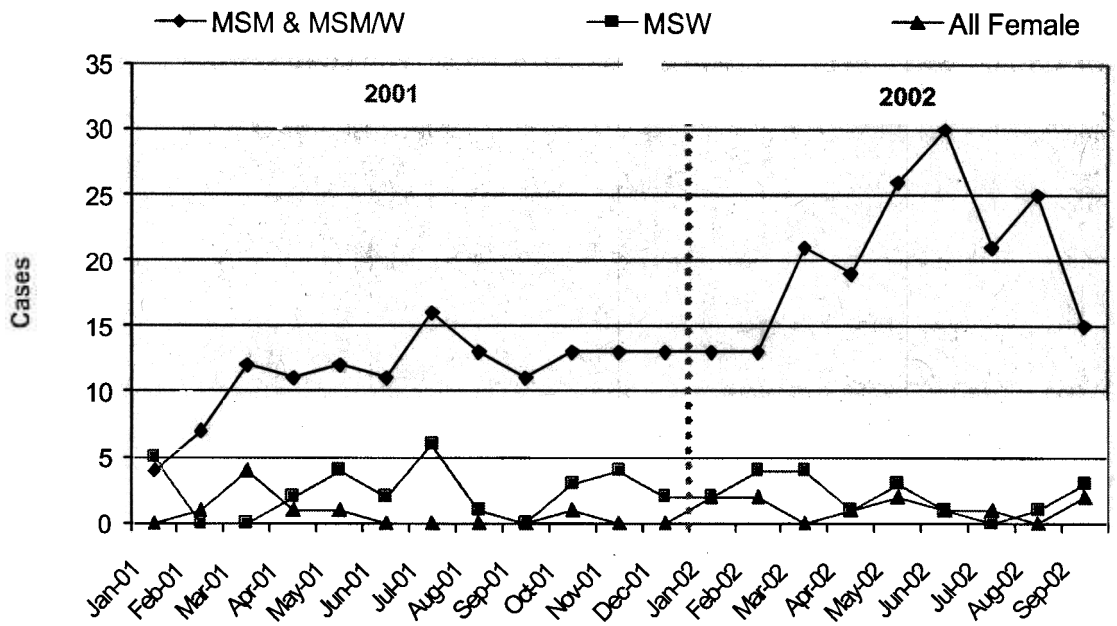


Figure 4: Early Syphilis by Sexual Orientation* & Month of Diagnosis, January 2001 Through September 2002 (n=794)



*Does not include cases lacking partner information

Figure 5: Primary & Secondary Syphilis by Sexual Orientation* & Month of Diagnosis, January 2001 Through September 2002 (n=406)



*Does not include cases lacking partner information

Figure 6: Primary & Secondary Syphilis by Race/Ethnicity Among MSM, January Through November 2002 (n=202)

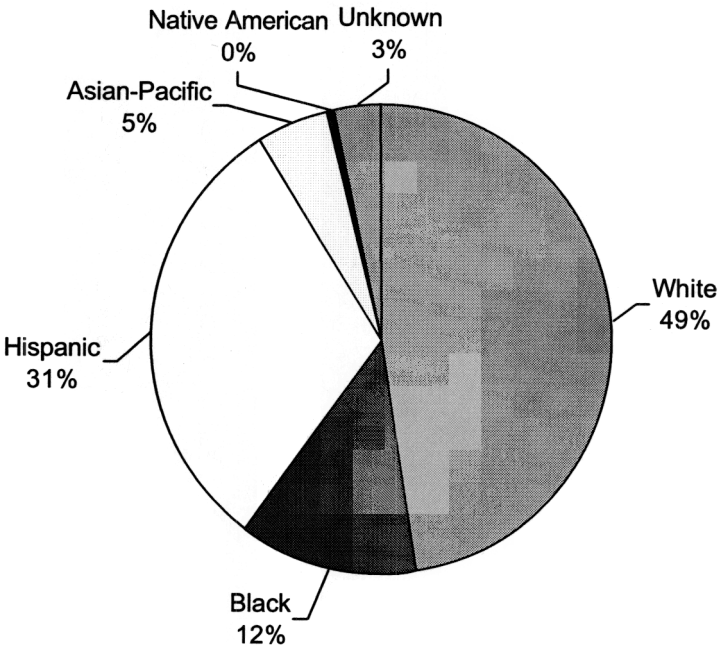


Figure 7: Primary & Secondary Syphilis by Race/Ethnicity Among Non-MSM, January Through November 2002 (n=62)

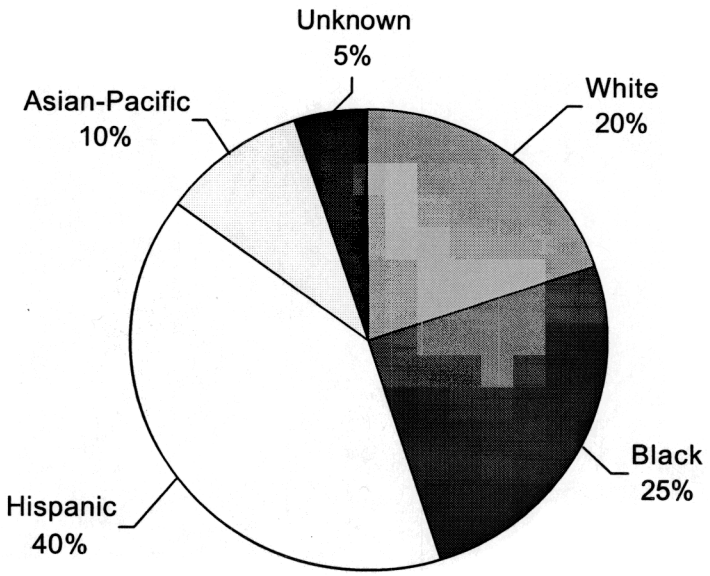


Figure 8: Primary & Secondary Syphilis by Age Group & Sexual Orientation, January Through November 2002 (n=264)

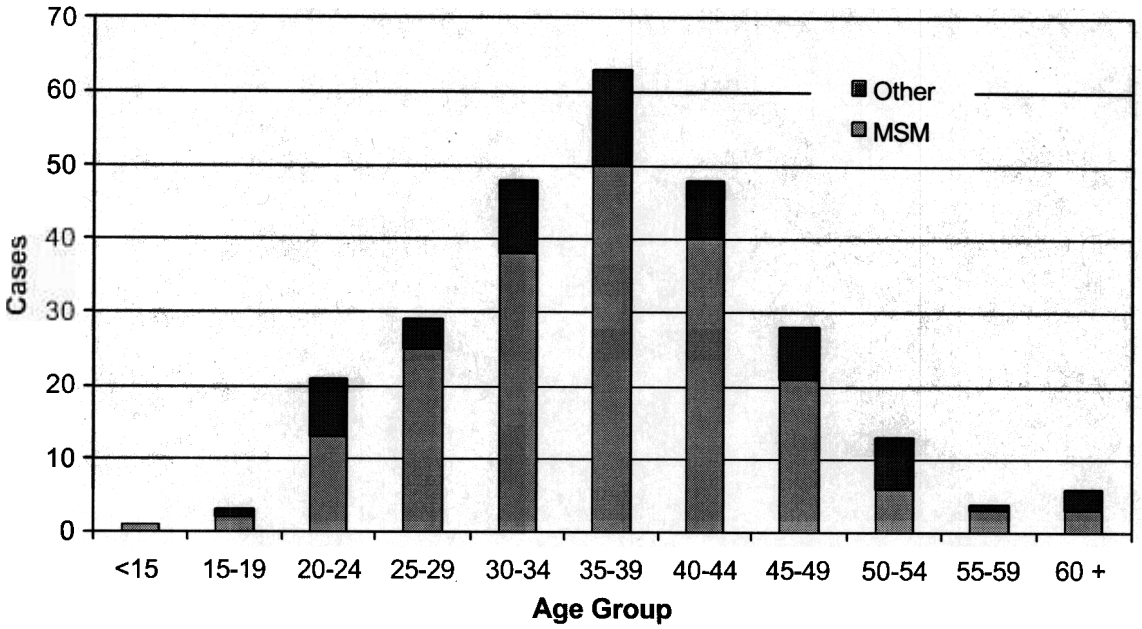
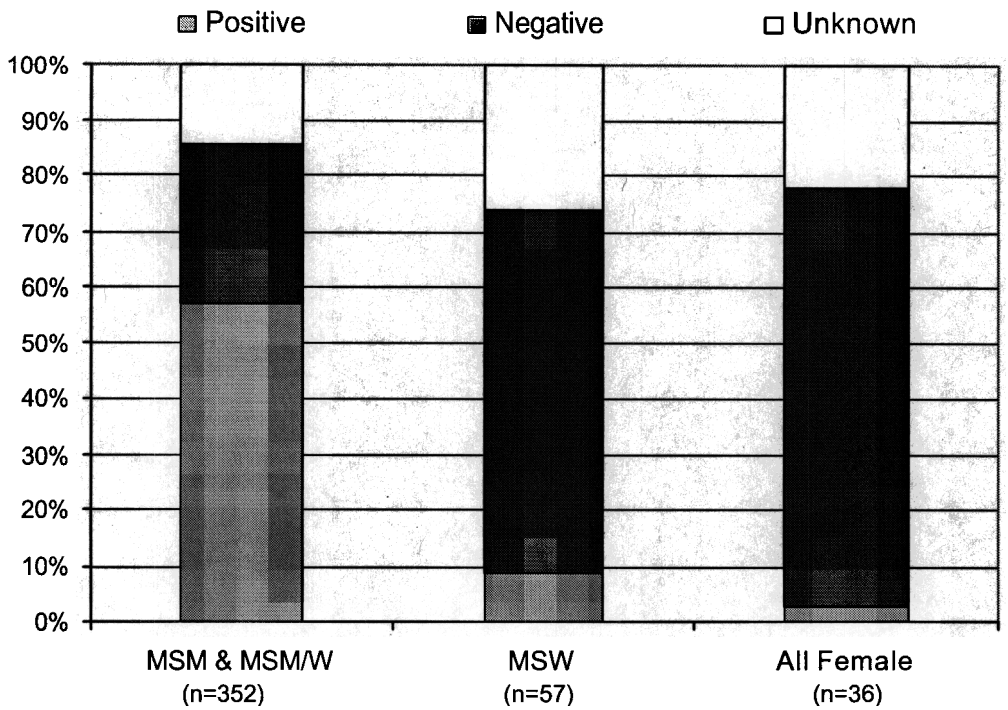


Figure 9: Early Syphilis Cases by HIV Serostatus & Sexual Orientation, January Through November 2002 (n=445)



APPENDIX A: SURVEILLANCE NOTES

REPORT DELAY

Report delay is defined as the time interval between the date a syphilis diagnosis was made and the date the case was reported to the Health Department. Currently, the mean reporting delay for early syphilis is 20 days and the 95th percentile is 72 days. The impact of report delay must be considered when evaluating figures 1, 4, and 5.

DATABASE UPDATES

Totals may not be consistent with previous reports of previous years due to periodic updates of the database, including the changes in diagnosis, late reporting, and some deletion of duplicate cases.

APPENDIX B: EARLY SYPHILIS CASE DEFINITION FOR INFECTIOUS CONDITIONS UNDER PUBLIC HEALTH SURVEILLANCE

State and local public health officials rely on health-care providers, laboratories, and other public health personnel to report the occurrence of reportable diseases to state and local health departments. Without such data, trends cannot be accurately monitored, unusual occurrences of diseases might not be detected, and the effectiveness of intervention activities cannot be easily evaluated.

The usefulness of public health surveillance data depends on its uniformity, simplicity, and timeliness. This case definition was established for uniform criteria for disease reporting and should not be used as the sole criteria for establishing clinical diagnoses, determining the standard of care necessary for a particular patient, setting guidelines for quality assurance, or providing standards for reimbursement. Use of additional clinical, epidemiological, and laboratory data may enable a physician to diagnose a disease even though the formal surveillance case definition may not be met.

This case definition was developed in collaboration with epidemiologists at the Centers for Disease Control and Prevention (CDC) and the Council of State and Territorial Epidemiologists (CSTE). It was approved by a full vote of the CSTE membership and also endorsed for use by the Association of Public Health Laboratories (APHL).

EARLY SYPHILIS CASE DEFINITION

Early syphilis includes primary, secondary and early latent cases reported within less than one year from the date of infection.

Syphilis is a complex sexually transmitted disease that has a highly variable clinical course. Classification by a clinician with expertise in syphilis may take precedence over the following case definitions developed for surveillance purposes.

PRIMARY SYPHILIS

Clinical description: A stage of infection with *Treponema pallidum* characterized by one or more chancres (ulcers); chancres might differ considerably in clinical appearance.

Laboratory criteria for diagnosis: Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, direct fluorescent antibody (DFA-TP), or equivalent methods.

Case classification - Probable: A clinically compatible case with one or more ulcers (chancres) consistent with primary syphilis and a reactive serologic test (nontreponemal: Venereal Disease Research Laboratory [VDRL] or rapid plasma reagin [RPR]; treponemal: fluorescent treponemal antibody absorbed [FTA-ABS] or microhemagglutination assay for antibody to *T. pallidum* [MHA-TP]).

Case classification - Confirmed: A clinically compatible case that is laboratory confirmed.

SECONDARY SYPHILIS

Clinical description: A stage of infection caused by *T. pallidum* and characterized by localized or diffuse mucocutaneous lesions, often with generalized lymphadenopathy. The primary chancre may still be present.

Laboratory criteria for diagnosis: Demonstration of *T. pallidum* in clinical specimens by dark field microscopy, DFA-TP, or equivalent methods.

Case classification - Probable: A clinically compatible case with a nontreponemal (VDRL or RPR) titer.

Case classification - Confirmed: A clinically compatible case that is laboratory confirmed.

EARLY LATENT SYPHILIS

Clinical description: A stage of infection caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs. Latent syphilis is subdivided into early, late and unknown categories based on the duration of infection. When initial infection has occurred within the previous 12 months, latent syphilis is classified as early latent.

Case classification - Probable: Latent syphilis in a person who has evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:

Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months
A history of symptoms consistent with primary or secondary syphilis during the previous 12 months·
A history of sexual exposure to a partner who had confirmed or probable primary or secondary syphilis or probable early latent syphilis (documented independently as duration <1 year)
Reactive nontreponemal and treponemal tests from a person whose only possible exposure occurred within the preceding 12 months

Source: Case Definitions for Infectious Conditions Under Public Health Surveillance, MMWR, May 2, 1997, Vol. 46 , No. RR-10

APPENDIX C: LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL MORBIDITY REPORT

Mail to: STD PROGRAM, 2615 S. Grand Avenue, Rm. 450, Los Angeles, CA 90007
Fax to: (213) 749-9602 or (213) 749-9606

PATIENT DEMOGRAPHICS

PATIENT'S LAST NAME | MEDICAL RECORD NUMBER

FIRST NAME | M.I. | SOCIAL SECURITY NUMBER

ADDRESS | APT/UNIT NO. | AGE | BIRTHDATE (MONTH / DAY / YEAR)

CITY/TOWN | STATE | ZIP CODE

AREA CODE HOME/CELL TELEPHONE # | AREA CODE WORK TELEPHONE #

GENDER: ☐ Male ☐ Female ☐ Transgender (M to F) ☐ Transgender (F to M) ☐ Unknown or Refused

PREGNANT ☐ Yes ☐ No ☐ Unknown | LMP (MONTH / DAY / YEAR)

GENDER OF SEX PARTNERS IN PAST 12 MONTHS: ☐ Only Females ☐ Only Males ☐ Both Males and Females ☐ Unknown ☐ Refused

RACE (✓only one)

- ☐ Native American or Alaska Native
- ☐ Asian or Asian American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Unknown
- ☐ Other:_____

ETHNICITY (✓only one)

- ☐ Hispanic or Latino
- ☐ Non Hispanic/ Non- Latino
- ☐ Unknown

MORBIDITY

CHLAMYDIA

DIAGNOSIS

☐ Asymptomatic

☐ Symptomatic (✓ all sites that apply)
☐ Cervix ☐ Urine ☐ Rectum
☐ Urethra ☐ Ophthalmia/Conjunctiva
☐ Nasopharynx ☐ Other_____
☐ Pelvic Inflammatory Disease

Laboratory Test (✓) Date: ____/____/____
☐ DNA Probe ☐ PCR ☐ SDA
☐ LCR ☐ TMA ☐ Other_____

Patient treated: ☐ **Yes** ☐ **No**
(If Yes, give treatment, dose, and date)

Date	Treatment/Dose

Partner Information (in the past 60 days)
# of partners elicited _____
# of partners referred _____
# of partners treated _____
# of partners dispensed PDT _____

GONORRHEA

DIAGNOSIS

☐ Asymptomatic

☐ Symptomatic (✓ all sites that apply)
☐ Cervix ☐ Urine ☐ Rectum
☐ Urethra ☐ Ophthalmia/Conjunctiva
☐ Nasopharynx ☐ Other_____
☐ Pelvic Inflammatory Disease

Laboratory Test (✓) Date:____/____/____
☐ DNA Probe ☐ Culture ☐ SDA
☐ LCR ☐ TMA ☐ Other_____

Patient treated: ☐ **Yes** ☐ **No**
(If Yes, give treatment, dose, and date)

Date	Treatment/Dose

Partner Information (in the past 60 days)
# of partners elicited _____
# of partners referred _____
# of partners treated _____

SYPHILIS

DIAGNOSIS

☐ **Primary onset date:** ____/____/____
Site primary lesion (✓ only one) ☐ Genital ☐ Rectal ☐ Pharynx ☐ Other_____
☐ **Secondary onset date:** ____/____/____
☐ Palmar/Plantar Rash ☐ Alopecia ☐ General Body Rash ☐ Other_____
☐ **Early Latent (≤1 Year)** ☐ **Late Latent (>1 year)**
☐ **Latent, Unknown Duration** ☐ **Congenital** (See Congenital Syphilis Section)
☐ **Tertiary** ☐ CNS ☐ Aortitis ☐ Gumma ☐ Iritis ☐ Other_____
Neurosyphilis: (CSF-VDRL Reactive) ☐ No ☐ Yes ☐ Not examined
Laboratory Test (✓) Date:____/____/____
☐ RPR or ☐ VDRL Titer 1:_____ Reactive ☐ TP-PA or ☐ FTA-ABS
☐ Other_____

Patient treated: ☐ **Yes** ☐ **No**
(If Yes, give treatment, dose, and date)

Date	Treatment/Dose

Partner Information* (*If 1°, past 90 days + duration of sx. If 2°, past 6mos + duration of sx. If early latent, past year + duration of sx)
# of partners elicited _____
# of partners referred _____
# of partners treated _____

COMMENTS: _____

CONGENITAL SYPHILIS

INFANT INFORMATION

☐ Live Birth ☐ Stillbirth Date of Birth:____/____ Gestational Age:____(weeks)

☐ Darkfield Positive Date:____/____ Site____

Long Bone X-rays
☐ Positive ☐ Negative

RPR Positive ☐ Yes ☐ No Titer 1:_____ ☐ Not examined

Serum: Titer 4x > mothers? ☐ Yes ☐ No

CSF: VDRL ☐ Reactive ☐ Non-Reactive
WBC > 5/mm³ ☐ Yes ☐ No
Protein > 50mg/dl ☐ Yes ☐ No

☐ Hepatosplenomegaly
☐ Asymptomatic
☐ Other _____

MATERNAL INFORMATION

Mother's Name:_____

Medical Record No._____ Date of Birth ____/____/____ (Month / Day / Year)

Country of Birth:_____ Arrival date in U.S.A.:_____

(Diagnosis/Stage of Syphilis)_____

Date(s) treated _____ at _____ (MD/Facility)

Mother's Serology at delivery:

		Date	Titer
	RPR or VDRL		
	Syphilis-G EIA		
Reactive	FTA-ABS		
Reactive	TP-PA		

OTHER REPORTABLE STDs

☐ NGU: Non-Chlamydial
Rx: ☐ Yes Date:____/____/____ ☐ No

☐ PID: Non-Gonococcal/Non-Chlamydial
Rx: ☐ Yes Date:____/____/____ ☐ No

☐ Chancroid Rx: ☐ Yes Date:____/____/____ ☐ No

DATE OF REPORT ____/____/____ (Month / Day / Year)

REPORT SUBMITTED BY:

Name_____ Title_____

Facility/Clinic_____

Address _____

City_____ State _____

Zip_____ Phone # (____) _____

USE OF THE STD CONFIDENTIAL MORBIDITY REPORT

Confidential Morbidity Report is available on the internet at: www.lapublichealth.org/std/forproviders/stdprov.htm
To request CMR forms call: (213) 744-3252

REPORTING
This report is designed for health care providers to report sexually transmitted diseases mandated by state law (California Administrative Code, Title 17, Public Health, Section 2500, 1990). These diseases are of such major public health concern that surveillance of their occurrence is in the public interest.

Syphilis case reports should be submitted within one (1) working day. All case reports for other reportable STDs should be submitted within seven (7) days. All case report information will be managed in the strictest confidence. Your cooperation in reporting is both encouraged and appreciated.

PARTNER SERVICES
All health care providers are urged to encourage patients with STDs to refer their sexual partners so that those partners can seek appropriate medical evaluation and treatment. California physicians are required by law to: 1) endeavor to discover the source of the infection, as well as any sexual contacts that the patient made while in the communicable stage of the disease; 2) make an effort, through cooperation of the patient, to bring those persons in for examination and, if necessary, treatment; and 3) report case to the local health officer (California Code of Regulations, Title 17, 2636). A new law (Health and Safety code 120582) allows health care providers to provide treatment for chlamydia to partners without an exam. This is called Patient-Delivered Partner Therapy or PDPT. STD Program staff are available to assist in partner notification, evaluation, and treatment. For assistance with case reporting, treatment, or related issues for all STDs, please contact the Los Angeles County Sexually Transmitted Disease Program at **(213) 744-3070.**

CRITERIA FOR REPORTING SELECTED STDs

More detailed criteria for diagnosis are available on the internet at: www.lapublichealth.org/std/diseases/stddef.htm

NGU/PID
Cases of urethritis or pelvic inflammatory disease, where tests for gonorrhea or chlamydia are negative or have not been performed; should be reported as NGU or PID under "OTHER REPORTABLE STDs".

CHANCROID
Laboratory confirmation by isolation of H. ducreyi **OR** compatible clinical picture as evidenced by 1 or more painful genital ulcers and inguinal adenopathy **PLUS** lab exclusion of syphilis or HSV

PRIMARY SYPHILIS
Compatible clinical picture as evidenced by 1or more painless indurated ulcers at the site of exposure **AND** laboratory confirmation by either a) demonstration of T. pallidum by darkfield of fluorescent antibody methods or b) reactive serological test for syphilis. ** Current serologic tests may not become positive until 7-10 days following appearance of the lesion.

SECONDARY SYPHILIS
Identification of T. pallidum from a lesion compatible with secondary syphilis **OR** compatible clinical picture as evidenced by palmar/plantar rash, localized or diffuse mucocutaneous lesions, alopecia, or generalized lymphadenopathy **PLUS** laboratory confirmation by either a or b: a) Reactive nontreponemal test (> 1:4) with no prior diagnosis of syphilis; b) Four-fold or greater increase in nontreponemal test titer compared with most recent test for individuals with prior history of syphilis.

EARLY LATENT SYPHILIS (under 1 year)
Reactive treponemal and nontreponemal test, **AND** initial infection that has occurred within previous 12 months as demonstrated by either a, b, or c: a) Nonreactive or four-fold lower titer nontreponemal test within past 12 months; b) History consistent with untreated primary or secondary syphilis in the past 12 months; c) Sexual exposure to a partner with primary, secondary or early latent syphilis in the past 12 months, and no history of treatment for syphilis following the exposure.

NEUROSYPHILIS
Clinical suspicion of central nervous system involvement warrants CSF evaluation of any stage of syphilis. Neurosyphilis may occur earlier and more frequently in HIV-infected individuals.

HIV
HIV reporting is now state mandated using a non-name identification code. HIV/AIDS cases should be submitted on report form **DHS8641** to the HIV Epidemiology Department. Please refer additional questions regarding HIV reporting to the HIV Epidemiology Program at **(213) 351-8516.**

APPENDIX D: LOS ANGELES COUNTY STD SCREENING GUIDELINES FOR SEXUALLY ACTIVE HIV POSITIVE PERSONS

Due to the continuing rise in syphilis as well as gonorrhea and chlamydia, we recommend routine screening of HIV infected persons based on the following schedule in order to decrease the transmission of these curable STDs as well as HIV.

INITIAL VISIT AND ANNUAL VISIT

Testing should be performed for gonorrhea and chlamydia using urine testing for men and/or endocervical swab testing for women. Gonorrhea culture may also be used. Syphilis screening should be performed with an RPR.

a. Patients engaging in rectal intercourse should be cultured for GC and CT from the anal site. DFA may also be used for chlamydia.

b. Patients engaging in oral sex defined as activity in which they are orally exposed should be cultured for GC and CT from the pharyngeal area. DFA may also be used for chlamydia.

2. Women should be evaluated for the above trichomoniasis using culture or vaginal wet mount.

FOLLOW-UP VISITS

(ANNUAL VISIT AS ABOVE)

HIV infected persons with symptoms of an STD should be screened upon presentation for care. Screening for syphilis, GC, and CT should be performed at 3 to 6 month intervals for persons at high risk for STDs but without STD symptoms. These persons include but are not limited to:

1. Persons with multiple or anonymous sex partners.
2. Past history of any STD.
3. Persons who have been recently incarcerated or those who have had sexual relations with someone recently incarcerated.
4. Persons reporting other behaviors associated with the transmission of HIV and other STDs. These include:

   a. Participation in sexual activities in bathhouses, sex clubs or circuit parties,

   b. Use of the internet to recruit sex partners,

   c. Engaging in sexual activity for money or drugs,

   d. Use of sexual enhancement drugs such as methamphetamines (i.e., meth, glass, crystal), ecstasy, ketamine, viagra, cocaine, crack, GHB, and nitrates/poppers.

5. Persons with sex or needle sharing partner(s) with any of the above risks.
6. Persons using injection drugs.
7. Persons living on the street/homeless.
8. Person living in areas with high STD prevalence. Sexually active gay men in the Los Angeles area are considered high-risk.

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
Public Health

SEXUALLY TRANSMITTED DISEASE PROGRAM

2615 South Grand Avenue, Room 500
Los Angeles, California 90007