



## Syphilis Trends in South Florida

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One of the most significant public health issues facing Men Who Have Sex With Men (MSM) in South Florida is the dramatic and sustained increase in infectious (primary and secondary) and early latent syphilis. Recent studies have shown that syphilis and other STDs increase the likelihood of sexual HIV transmission by 200-500%.

In many major U.S. cities there has been resurgence in syphilis among MSM, and men who have not identified themselves as having sex with men. Of major concern in Florida through the first six months of 2003 are the significant increases in Broward County, Ft. Lauderdale (from 19 to 55 cases, 54.5%), Hillsborough County, Tampa (9 to 22 cases, 144.4%), Orange County, Orlando (18 to 33 cases, 83.3%) and Pinellas County, St. Petersburg (from 10 to 25 cases, 150%). The majority of cases reported are among MSMs and over 40% of those MSM cases have either a documented, or self-reported history of a positive HIV antibody test.

In Miami-Dade County, we continue to experience a sustained number of infectious syphilis cases (93 cases January - June 2003).

Also, Miami-Dade continues to experience an increase in syphilis cases among MSM, and, as in other counties, a significant proportion of these cases are also co-infected with HIV.

For the first six months of 2003, Broward and Miami-Dade Counties accounted for 56.5% of the infectious syphilis cases reported in Florida. Comparisons and contrasts of the demographics for infectious syphilis cases in these two counties during 2002 are as follows:

- 231 infectious syphilis cases were reported in Miami-Dade. Men accounted for 86% of the reported infectious syphilis cases, of the male cases interviewed, 63% claimed MSM or bisexual contacts.
- In 2002, of the 133 infectious syphilis cases reported in Broward, men accounted for 95%, and, of these male cases interviewed, 95% claimed MSM or bisexual contacts.
- In both Broward and Miami-Dade, over the last 2 years, the majority of the infectious syphilis cases fell into the age group 35-39 years.

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- In 2002, 44% of infectious syphilis cases in Miami-Dade were among Hispanics, 33% among Blacks and 13% among Caucasians.
- In Broward, 66% of the infectious syphilis cases were among Whites, 21% among Blacks and 12% among Hispanics.

The STD Program has responded to the increase with a multi-faceted approach. This includes the following:

- 1) Creation and distribution of media messages
- 2) Increase in STD clinic access
- 3) Development of Memorandum of Agreement (MOA's) with 12 Community Base Organization (CBO's) in South Florida, to screen at risk clients for syphilis
- 4) Initiation of the Jail Screening Project
- 5) Expanded syphilis screening and laboratory services
- 6) Increase in community involvement and awareness, e.g., South Beach Syphilis Elimination Group "SOBE SYPH"
- 7) Social marketing contract with United Foundation for AIDS
- 8) A grant award from the CDC to Broward and Miami-Dade to develop intervention strategies among the MSM community.

### Comments

There has been an expansion of the sexual marketplace and changes in sexual networks (e.g., internet chat rooms). We seem to be dealing more with men who are: 1) A more professional type of person, 2) More educated, and 3) Empowered with information and knowledge of the risks involved.

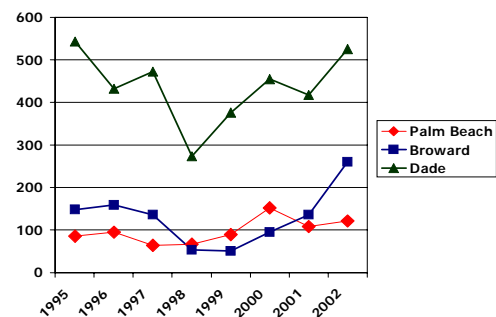
Our conventional public health methods have contributed to the decline in syphilis among certain populations (e.g., women). However, these methods (i.e., enhanced surveillance, screening and partner notification and collaboration with community based organizations) don't appear to be as effective in the MSM population. Perhaps, public health needs to explore:

- 1) New diagnostics
- 2) New therapeutics and
- 3) New prevention approaches.

## THE STAGES OF SYPHILIS

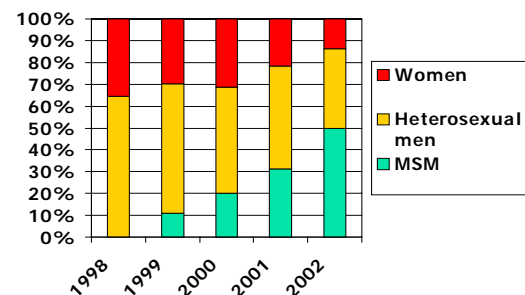
1. **Primary Syphilis:** after an incubation period of 10-90 days, the first symptom is a chancre followed by sight fever and other constitutional symptoms
2. **Secondary Syphilis:** a skin eruption of various appearances with mucous patches and with associated lymph.
3. **Early Latent Syphilis:** after the primary and secondary phases have subsided, during the first year after infection, before any manifestation of tertiary.
4. **Tertiary Syphilis:** involvement of the cardiovascular or central nervous system, or the development of a gumma (an infectious granuloma) in any organ.

Early Syphilis Cases Reported by County  
1995-2002 Same Period: Jan-Dec



Data Source: Bureau of STD Control and Prevention

Infectious Syphilis in Miami-Dade County, Florida  
1998-2002

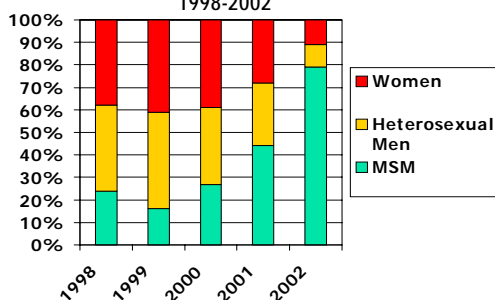


Data Source: Bureau of STD Control and Prevention



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Infectious Syphilis in Broward County, Florida  
1998-2002



Data Source: Bureau of STD Control and Prevention

## Update: AIDS and HIV cases Reported with No Identified Risk (NIR), Miami- Dade County, 2003

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### What is an NIR?

According to the Centers for Disease Control and Prevention (CDC), an HIV/AIDS case with no identified risk (NIR) indicates that the risk factor for HIV is unknown, not determined or denied. Also cases noting sex with the opposite sex, but lacking HIV status of the partner/s or their risk factors will result as an NIR.

### How many cases have been reported as NIRs?

As of September 2003, 36,698 cases of HIV/AIDS had been reported in Miami-Dade County, and 27% of those cases lack identifying risk information.

### Why are we having so many NIR cases?

In general, persons diagnosed with AIDS are often more comfortable acknowledging a past risk behavior than a person who recently tested

positive for HIV. Additionally, persons diagnosed with AIDS tend to be more aware of past partners' risk status, compared to persons newly diagnosed with HIV. Surveillance for HIV cases differs from that for AIDS cases. An AIDS case report requires reading of a medical record by the surveillance staff or by the medical staff who reported the case. This effort is likely to capture a risk factor if documented in the medical record. However an HIV case can be reported based solely on a HIV laboratory report, without the review of a medical record. Information on risk is not collected in most private laboratory report forms, with the exception of HIV cases reported by the state laboratory. Thus, in some instances, the initial source of report for an HIV case will not identify a risk. Over 50% of the HIV cases are initially reported without a risk factor. Later it may be added if it is identified.

Other reasons associated with the increased number of NIRs include: increased volume following revised AIDS case definition, limited surveillance staff to conduct investigations, increase in heterosexual transmission of HIV to persons without known risk factor, and lack of elicitation/documentation of risk factors associated with HIV transmission by the health care providers.

### What we are doing about it?

In 1999, the Miami-Dade County Prevention Committee of the HIV/AIDS Partnership looked into the issue of NIRs and a decision was made to incorporate it for the first time in the 1999-2000 HIV/AIDS Prevention Plan.

Several action steps to reduce the NIRs were planned. One of the goals was to increase the Surveillance staff by two employees who would work exclusively on NIR cases. Six months later, the Miami-Dade County Health Department (MDCHD) hired two full time employees (FTE) to address this issue.



Upon completion of their training in February 2000, they became actively engaged in the community, working with healthcare providers and reviewing many records. Furthermore, by the end of 2002, one more FTE began working on NIR cases reported by the county's top NIR providers.

The MDCHD will continue to help providers to investigate risk associated with HIV transmission. We will continue educating and promoting more thorough investigation of HIV risk factors by physicians, and we will continue getting access to databases that could be useful in NIR reclassification process. In addition, we will continue identifying on a periodic basis the top ten reporting providers of HIV/AIDS cases with the highest number of NIRs, and offer them technical assistance.

### **What are the results obtained so far?**

From March 2000 up to September 2003, we have reclassified or closed 5,863 HIV/AIDS cases, reducing the cumulative percentage of AIDS NIR cases by 20% and of HIV NIR cases by 31%. As of September 2003, the cumulative percentage of HIV and AIDS NIR cases are 41% and 22% respectively.

### **What are the future challenges?**

As of September 2003, 7,419 HIV/AIDS cases are still classified as NIRs and pending NIR investigation. In addition, we have 2,504 cases that have been reviewed, but where no risk information was obtained to reclassify these cases. In other words we have, 9,924 open NIRs that need to be investigated and reclassified.

Even though we have observed a decreasing trend in the cumulative percentage of HIV and AIDS NIRs, we have not reached the Florida standard of fewer than 35% cumulative HIV NIR cases, and fewer than 15% cumulative AIDS NIR cases annually.

### **Why is it so important to collect risk information and reclassify the NIRs?**

Accurate information regarding transmission

modes is essential for the following reasons:

- To effectively counsel the client regarding the spread of HIV;
- To monitor changing patterns of transmission;
- To assist in targeting funding, prevention services, and other programs to populations at increased risk;
- To detect any unusual transmission.

### **How can health care providers help with the NIR problem?**

- Explain to their clients that in the vast majority of AIDS cases, HIV was acquired through identified transmission routes.
- Review the different high-risk exposures with the client, including the need for details on heterosexual transmission.
- If a risk on an HIV/AIDS client is identified, the local HIV/AIDS Surveillance staff should be notified, regardless of how much time has elapsed since the case was reported, and regardless of whom the provider was who initially reported the case.
- If a new or unusual transmission route is suspected, the local HIV/AIDS surveillance contact should be notified as soon as possible.

Finally, it should always be remembered that as additional risks are identified by providers and forwarded to the HIV/AIDS Surveillance staff, the risk data will become more complete. This will provide a more complete picture of the epidemic, and allow better targeting of HIV prevention messages.

For further questions contact your local HIV/AIDS surveillance person or contact one of our NIR specialists, at (305) 324-2459.



## Respiratory Hygiene/Cough Etiquette in Healthcare Settings

The full article can be downloaded from:  
<http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>

To prevent the transmission of all respiratory infections in healthcare settings, including influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person. They should be incorporated into infection control practices as one component of Standard Precautions.

### 1. Visual Alerts

Post visual alerts (in appropriate languages) at the entrance to outpatient facilities (e.g., emergency departments, physician offices, outpatient clinics) instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection when they first register for care and to practice Respiratory Hygiene/Cough Etiquette.

### 2. Respiratory Hygiene/Cough Etiquette

The following measures to contain respiratory secretions are recommended for all individuals

- Cover the nose/mouth when coughing or sneezing;
- Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
- Perform hand hygiene (e.g., hand washing with non-antimicrobials soap and water, alcohol-based hand rub, or antiseptic hand-wash ) after having contact with respiratory secretions and contaminated objects/materials. Healthcare facilities should ensure the availability of materials for adhering to Respiratory Hygiene/Cough Etiquette in waiting areas for patients and visitors.
- Provide tissues and no-touch receptacles for used tissue disposal.
- Provide conveniently located dispensers of alcohol-based hand rub; where sinks are avail-

able, ensure that supplies for hand washing (i.e., soap, disposable towels) are consistently available.

### 3. Masking and Separation of Persons with Respiratory Symptoms

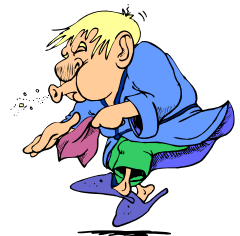
During periods of increased respiratory infection activity in the community (e.g., when there is increased absenteeism in schools and work settings and increased medical office visits by persons complaining of respiratory illness), offer masks to persons who are coughing. Either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions (respirators such as N-95 or above are not necessary for this purpose). When space and chair availability permit, encourage coughing persons to sit at least three feet away from others in common waiting areas. Some facilities may find it logistically easier to institute this recommendation year-round.

### 4. Droplet Precautions

Advise healthcare personnel to observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions

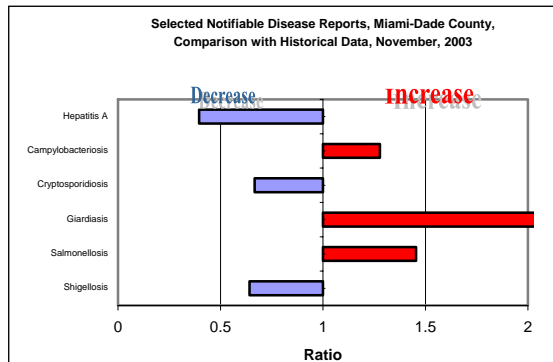
[www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm](http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm).

**NOTE:** These recommendations are based on the *Draft Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC), CDC.

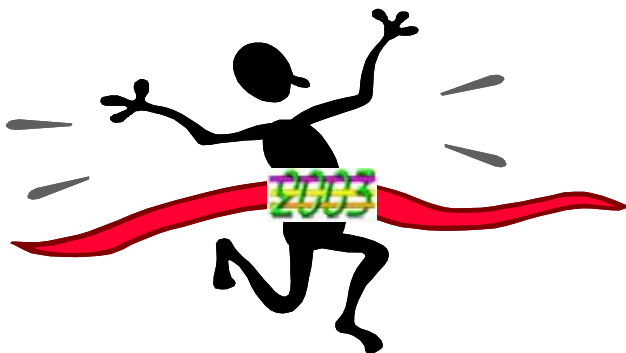


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\*Ratio of current month total to mean of 15 month totals (from previous, comparable, and subsequent month periods for the past 5 years).



#### To report diseases or for information:

##### Office of Epidemiology and Disease Control

Childhood Lead Poisoning  
Prevention Program (305) 623-3565  
Hepatitis (305) 324-2490  
Other diseases and outbreaks (305) 324-2413

HIV/AIDS Program (305) 324-2459  
STD Program (305) 325-3242  
Tuberculosis Program (305) 324-2470  
Special Immunization Program (786) 845-0550

Nights, weekends, and holidays  
(305) 377-6751

Wishing all of You a Very Merry Holiday Season



Dear Colleagues,

*This has been a wonderful year!!*  
We would like to thank you for your assistance and collaboration in the surveillance and control of communicable and other diseases in our community.  
May the spirit of the season bring the promise of a wonderful new year.

Happy new year!!

From all Staff of Miami-Dade  
County Health Department  
Office of Epidemiology and  
Disease Control



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# Monthly Report

## Selected Reportable Diseases/Conditions in Miami-Dade County, November 2003

Diseases/Conditions	2003 this Month	2003 Year to Date	2002 Year to Date	2001 Year to Date	2000 Year to Date	1999 Year to Date
AIDS <sup>Provisional</sup>	64	967	1043	1158	1271	1263
Animal Rabies	0	0	0	0	0	0
Campylobacteriosis	17	132	102	106	142	132
<i>Chlamydia trachomatis</i>	104	3604	4320	3381	2869	3932
Ciguatera Poisoning	0	0	2	0	2	0
Cryptosporidiosis	2	13	12	11	29	21
Cyclosporiasis	0	1	1	0	0	0
Diphtheria	0	0	0	0	0	0
<i>E. coli</i> , O157:H7	0	0	0	2	3	5
<i>E. coli</i> , Non-O157	0	3	2	1	0	0
<i>E. coli</i> , Other	0	0	0	0	0	0
Encephalitis (except WNV)	0	0	1	0	0	0
Encephalitis, West Nile Virus	0	5	1	0	0	0
Giardiasis, Acute	42	196	204	227	225	126
Gonorrhea	65	1548	1847	1728	1884	2720
Granuloma Inguinale	0	0	0	0	0	0
Hepatitis A	4	56	133	170	100	89
Hepatitis B	2	47	41	63	114	28
HIV <sup>Provisional</sup>	102	1593	1820	1621	1699	1858
Lead Poisoning	39	253	273	233	383	295
Legionnaire's Disease	3	8	0	3	0	0
Leptospirosis	0	0	0	0	0	1
Lyme disease	0	3	2	6	7	0
Lymphogranuloma Venereum	0	0	0	0	0	0
Malaria	0	12	12	17	21	17
Measles	0	0	0	0	0	0
Meningitis (except aseptic)	0	7	10	9	15	9
Meningococcal Disease	0	4	11	15	24	15
Mumps	0	0	0	0	2	2
Pertussis	0	9	6	2	7	12
Polio	0	0	0	0	0	0
Rubella	0	0	0	0	0	0
Rubella, Congenital	0	0	0	0	1	0
Salmonellosis	49	490	306	269	254	303
Shigellosis	12	275	224	127	211	181
<i>Streptococcus pneumoniae</i> , Drug Resistant	0	105	98	150	172	75
Syphilis, Infectious	16	175	200	175	129	68
Syphilis, Other	67	931	1024	798	687	640
Tetanus	0	0	0	1	1	0
Toxoplasmosis	0	9	22	11	0	2
Tuberculosis <sup>Provisional</sup>	21	194	206	209	230	239
Typhoid Fever	0	4	4	2	2	16
<i>Vibrio cholera</i> Type O1	0	0	0	0	0	0
<i>Vibrio cholera</i> Non-O1	0	0	1	0	0	0
<i>Vibrio</i> , Other	0	1	0	0	0	0

\* Data on AIDS are provisional at the county level and are subject to edit checks by state and federal agencies.

\*\* Data on tuberculosis are provisional at the county level.



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