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California Stories

Gonorrhea Rate Has Shot Up In California

Barbara Feder Ostrov, California Healthline | 4.19

Rates of gonorrhea, a sexually transmitted disease, are rising sharply in California, especially among gay and bisexual men, according to new state health data.

The gonorrhea rate among California men aged 15 to 44 shot up 54 percent between 2011 and 2014, according to recently released data from the California Department of Public Health. Among women in the same age group, it rose 35 percent.

An average of 34,000 gonorrhea cases among 15-to-44 year-olds was reported in California each year between 2012 and 2014, most of them among men.

By contrast, the national gonorrhea rate, calculated slightly differently than California's, rose about 15 percent among men aged 15-44 between 2010 and 2013, the latest available data for that group.

Public health experts say the reasons for gonorrhea's resurgence in California are complex. It may reflect better screening, which detects cases that would not have been found previously.

Other possible explanations include lower condom use among young people and the rise of Tinder and other "hookup" apps that promote multiple sex partners. But experts say there's not enough data to pin the rising gonorrhea rates on any one cause.

Clinicians say they are frustrated they haven't made more headway in controlling the disease.

"We have great testing, [and the] medications are highly effective," said Dr. Heidi Bauer, chief of the Sexually Transmitted Disease Control Branch of the California Department of Public Health. "This should not be an ongoing health problem. We should be able to do a much better job."

The disease is continuing to spread in part because some people do not notify their partners so they can be treated, and local public health workers don't always have the resources to track down and inform them, Bauer said.

Gonorrhea is caused by the bacterium *Neisseria gonorrhoeae*, which can be transmitted through vaginal, anal or oral sex. Sometimes called "the clap," the disease has afflicted humans at least since medieval times.

Gonorrhea can be cured with antibiotics, but if left untreated, it can cause infertility or inflammatory pelvic disease and increase the risk of contracting or transmitting HIV. Women often don't know that they're infected, because many don't experience symptoms.

Typical symptoms in men include discharge from the penis or a burning sensation while urinating. But not all men experience these symptoms.

Rates of other sexually transmitted diseases are rising as well. The rate of syphilis has increased in California and nationally, though the actual number of cases is far smaller than for gonorrhea. Rates of chlamydia, which affects far more people than syphilis or gonorrhea, climbed about 7 percent between 2011 and 2014 among men and women of all ages.

However, the rate of AIDS among Californians age 13 years and older has declined.

In the universe of sexually transmitted diseases, gonorrhea traditionally hasn't been as worrisome to public health officials as HIV/AIDS or syphilis, because its effects are not as severe and it can easily be treated.

New strains of antibiotic-resistant gonorrhea bacteria, however, have put epidemiologists around the world on alert.

Fortunately, new and aggressive treatment for gonorrhea, involving two types of antibiotics, appears to be keeping that strain at bay in California, Bauer said. Because many gonorrhea infections don't cause symptoms, cases are increasingly being discovered through routine testing, Bauer said.

The increased rates are concentrated mostly among gay and bisexual men, and people age 15 to 24. There are regional differences, too. Rates are higher in California's Central Valley and the Sacramento region than elsewhere in the state. Those differences might reflect variations in testing and access to care.

Clinicians now screen for asymptomatic infections in the mouth and anus, and some standard chlamydia tests also pick up gonorrhea infections. Use of PrEP – a medication regimen to prevent HIV infection – also has spurred more tests, because clinicians recommend that people using the regimen be tested for STDs every three months.

Bauer suggested that Californians newly insured under The Affordable Care Act and the state's Medicaid expansion also may have increased access to testing.

But just because more people are insured doesn't mean they have access to treatment, particularly in rural areas, said Claire Feldman, director of Statewide STD Prevention Programs for the California Family Health Council, which receives federal money for family planning and reproductive health services at clinics around the state.

Feldman noted that many county-run STD clinics have closed because primary care physicians increasingly include STD screening among their preventive health care services. And there's too little funding for sexual health education, particularly among high risk groups, she said.

"There's more screening, but that doesn't mean that treatment and prevention are being provided to curb reinfection rates or the spread of these sexually transmitted diseases," Feldman said. "It's a very complex issue and there are no easy answers."

View the story online: [Click here](#)

National Stories

More people with HIV are achieving viral suppression in US, but about 40% remain above transmission thresholds

Liz Highleyman, aidsmap | 4.7

A growing proportion of people with HIV are reaching an undetectable viral load on antiretroviral therapy (ART), according to a pair of studies from the US Centers for Disease Control and Prevention presented at the Conference on Retroviruses and Opportunistic Infections (CROI 2016) last month in Boston. Despite this improvement, however, a substantial number of people are still not achieving viral suppression, putting them at risk for disease progression and onward transmission of the virus.

Experts have developed the 'continuum of care' concept to characterise how people with HIV progress through the steps of diagnosis, linkage to care, starting ART and achieving viral suppression. In 2014 the CDC reported that while 86% of the estimated 1.2 million people living with HIV in the US in 2011 had been diagnosed, just 40% were engaged in HIV medical care and only 30% had achieved undetectable viral load.

Medical Monitoring Project

Heather Bradley and colleagues from the CDC used data from the national Medical Monitoring Project (MMP) during 2009-2013 to estimate the proportion of people receiving HIV medical care in the US who achieved viral suppression (< 200 copies/ml) at both their last test and all tests in the previous 12 months.

The researchers collected data from 23,125 people with HIV using interviews and medical record abstractions. They assessed trends over time in viral suppression overall and by sex, age, race/ethnicity and sexual behaviour/orientation.

The proportion of people with viral suppression at their most recent test rose steadily from 72% in 2009 to 80% in 2013. This upward trend was statistically significant for both men and women, for all age groups, for white, black and Hispanic people, and for gay/bisexual men and heterosexual men and women.

Large increases in viral suppression were seen in the 18-29 age group (rising from 56% in 2009 to 68% in 2013), the 30-39 age group (from 62% to 75%), African Americans (from 64% to 76%), women (from 66% to 77%) and men who have sex with men (from 76% to 82%).

Similarly, the proportion of people whose HIV was consistently suppressed on all tests during the previous 12 months increased steadily from 58% in 2009 to 68% in 2013. Again, the rising trend was significant for all sex, age, race/ethnicity and sexual behaviour/orientation groups.

Big increases in consistent viral suppression were seen in the same groups: age 18-29 (from 32% to 51%), age 30-39 (from 47% to 63%), black people (from 49% to 61%), women (from 52% to 64%) and men who have sex with men (from 61% to 71%).

Not surprisingly, increases in viral suppression reflected that a growing proportion of HIV-positive people in care were being prescribed ART, up from 89% in 2009 to 94% in 2013. But even after adjusting for rising prescription rates, increases in the proportion of people with undetectable viral load remained significant for most subgroups.

"Viral suppression increased significantly among adults in HIV medical care in the United States," the researchers concluded, with the "largest increases among subgroups with lowest levels of viral suppression in 2009".

"Enhanced efforts [are] needed to address social and behavioural factors affecting attainment of viral suppression," they added, including further reduction in medication burden and dosing frequency and increased access to supportive services.

Factors that may have contributed to greater viral suppression include broader guidelines recommending treatment for more – and eventually all – people with HIV, elimination of AIDS Drug Assistance Program (ADAP) waiting lists and ongoing improvements in the potency and tolerability of antiretroviral drugs.

"These findings are really encouraging in terms of improving the health of people living with HIV and preventing infection," Bradley said at a CROI press conference.

She noted, however, that these encouraging numbers are not directly comparable to those in the CDC's widely cited 2011 cascade of care report, as they refer to the proportion of HIV-positive people in medical care – not all people living with HIV – who have achieved viral suppression.

National HIV Surveillance System

As described in a related poster presentation, Nicole Crepaz of the CDC's Division of HIV/AIDS Prevention and colleagues looked at data from the National HIV Surveillance System (NHSS) to assess viral burden among people aged 13 and older who received an HIV diagnosis before 2011 and were still alive through 2013.

The analysis included data from people in 17 jurisdictions (16 states and Washington, DC) that reported CD4 cell count and viral load results to the NHSS. Three-quarters were men, 38% were black, 31% were white and 25% were Hispanic. Over half (56%) were men who have sex with men, 11% were people who inject drugs, and 12% were women and 5% were men exposed through heterosexual contact.

Of the 265,264 people with HIV in these jurisdictions who were engaged in care and had at least one viral load test in 2011, a total of 238,614 (95%) had at least two further viral load tests during 2012-2013. However, 14% had a gap of more than 12 months between tests.

Of the 238,641 people with at least two subsequent tests, 62% had durably suppressed viral load, or undetectable levels on all measurements. Men were more likely to have durable viral suppression than women (64% vs 55%), white people were more likely than Hispanic or black people (73%, 61% and 53%, respectively), and older age groups were more likely than younger ones (72% for > 55 years, 59% for 35-44 years, 38% for 13-24 years).

Among the 91,120 people (38%) without durably suppressed viral load, the mean number of days spent above 200 copies/ml was 438 – 60% of the two-year observation period. Further, an average of 316 days (about 40% of the period) were spent with a viral load above 1500 copies/ml and 215 days (about 30%) above 10,000, indicating a substantial risk of onward transmission.

Women, African Americans and young people had substantially higher mean viremia 'copy-years' and more days with viral load above 200, 1500 or 10,000 copies/ml. Gay men spent the least time with viral load under any of these thresholds. People with more than a 12-month gap between tests spent more time with elevated viral load (mean 337 days).

The researchers concluded that it is "encouraging" that nearly two-thirds of HIV-diagnosed people in care had suppressed viral load over a two-year period.

However, "persons without durable viral suppression spent an average of 60% of [the] two-year time with viral load above 200 copies/ml as well as a considerable length of time above 1500 or 10,000 copies/ml that considerably increase[s] the risk of transmitting HIV infection," they cautioned. "The high proportion of time these individuals spent above transmission risk thresholds raises concern because they were not isolated blips of viremia, but rather extended periods of many months of elevated transmission risk potential."

"Viral burden was higher among populations known from previous research to have suboptimal engagement in HIV-related medical care," they added. "Tailored care and treatment efforts are needed to address disparity in viral suppression."

References

Bradley H et al. *Increased HIV viral suppression among US adults receiving medical care, 2009-2013*. Conference on Retroviruses and Opportunistic Infections (CROI), Boston, abstract 53, 2016.

[View abstract on the conference website](#)

[View a webcast of this session on the conference website.](#)

Crepaz N et al. *Durable viral suppression among HIV-diagnosed persons – United States, 2012-2013*. Conference on Retroviruses and Opportunistic Infections (CROI), Boston, abstract 1033, 2016.

[View abstract on the conference website](#)

View the story online: [Click here](#)

Friday Feedback: The Impact of Zika on Reproductive Medicine

Could it have a chilling effect on pregnancies in this country?

Molly Walker, Medpage Today | 4.15

The Centers for Disease Control (CDC) announced that they have enough scientific evidence to prove a causal link between the Zika virus and microcephaly. Despite reports that Zika may arrive in certain southern parts of the U.S. by this summer, the CDC has still not recommended that women delay pregnancy.

We contacted reproductive medicine experts via email to ask:

If Zika virus becomes endemic to your area of the U.S., how will it impact how you counsel patients on any potential pregnancy?

How much of an impact do you think Zika virus in the U.S. will have on the field of reproductive medicine in general?

The participants this week are:

Alan S. Penzias, MD, surgical director, Boston IVF and associate professor, obstetrics, gynecology and reproductive biology at Harvard Medical School

Natali Aziz, MD, clinical associate professor, obstetrics and gynecology and director, Perinatal Infectious Diseases, Division of Maternal-Fetal Medicine at Stanford University School of Medicine in California

James Liu, MD, chairman, department of obstetrics and gynecology at UH Case Medical Center in Cleveland

John Thorp, Jr., MD, professor & division director, Women's Primary Healthcare and vice chair, research at University of North Carolina School of Medicine at Chapel Hill

Sean C. Blackwell, MD, chair, department of obstetrics, gynecology and reproductive sciences and professor, department of obstetrics, gynecology and reproductive sciences at McGovern Medical School at The University of Texas Health Science Center at Houston (UTHealth)

Stephanie T. Romero, MD, assistant professor, maternal fetal medicine at University of South Florida Morsani College of Medicine in Tampa

Carl P. Weiner, MD, K.E. Krantz professor and chair and associate director, Institute for Reproductive Health and Regenerative Medicine at University of Kansas Medical Center in Kansas City, Kan.

Nanette Santoro, MD, professor and E. Stewart Taylor chair, obstetrics and gynecology at University of Colorado School of Medicine in Aurora

Patient Education Key

Penzias: It will be all about preparation and precautions. We'd work with patients to define a time window for confirmed absence of Zika infection preconception and have a plan for using appropriate precautions during the conception window and throughout pregnancy.

Aziz: If Zika were to become endemic in the U.S., our counseling would entail prevention of Zika by use of mosquito repellents as well as sexual transmission prevention efforts, serial testing during the course of pregnancy (including at initiation of prenatal care and in mid-2nd trimester), and fetal surveillance by ultrasound.

Liu: It will be difficult to totally eradicate mosquitoes carrying Zika in endemic areas, so there will always be a risk of becoming infected with Zika. New information regarding Zika is fast changing. For those patients planning pregnancy who have had a Zika infection, they are immune to further infections and their pregnancies are not at risk. For those patients who are older and planning pregnancy, strict precautions to prevent mosquito bites would need to be instituted.

Thorp: Even if Zika becomes endemic, I would need to know about acquisition rates and how often babies are infected and affected. We also need to know more about effectiveness of insecticides. There is a lot of epidemiology left to be done before advice beyond avoiding mosquitoes can be given.

Shift in Focus

Blackwell: It will change our counseling in that we have been focusing on maternal and fetal risks primarily in women (and their spouses) who have traveled to South American or other areas with Zika outbreaks, but if we have evidence of local outbreaks, it will shift this focus to include a much larger group of women. Right now we don't know if there will be the same risks of maternal-fetal transmission and fetal effects as what is being described in Brazil.

Romero: Since I practice in Florida, in an area with a tropical climate where mosquitoes flourish and cruise ships come in and out daily, counseling about Zika is already a part of my encounters with patients. Once they become pregnant, I counsel my patients to take precautions against bites from *Aedes aegypti* mosquitoes, as recommended by the CDC. We don't know exactly how common it is for a fetus to develop abnormalities (such as microcephaly) when the mother is infected, but based on one case series from Brazil the rate appears to be about 29%.

Weiner: If Zika becomes established in the U.S. before we can effectively test for either prior or recent infection, the reproductive healthcare challenge will be significant since this mosquito is an aggressive daytime biter, lives indoors and out, and also bites at night. Further, there are multiple modes of transmission including intrauterine and perinatal transmission and sexual transmission plus several as yet unproven routes of infection. The virus also continues to be present for a relatively long period after the infection occurs, increasing the exposure period for pregnancy.

A Dramatic Effect

Santoro: The current guidelines will slow down reproductive medicine for couples who have travelled to endemic areas or who have had a confirmed Zika infection. Given what we know about Zika, couples who are contemplating pregnancy or who are actively trying to conceive should avoid endemic areas and should review the CDC guidelines and travel advisories frequently, as they are subject to change. Once a woman is pregnant, it is much more stressful dealing with the uncertainties of Zika. It can take up to 5 weeks to confirm an infection. During that time, there could be virally mediated damage to the pregnancy, so the stakes are awfully high!

Weiner: With the emergence of the Zika virus as a pregnancy threat, proactive planning of pregnancy will be more important than ever. Once endemic in the U.S., Zika will have a dramatic effect on reproductive healthcare until we have effective diagnostic tools, a smaller at-risk pool of patients, an understanding of the mechanism of damage, and ultimately a vaccine. The impact will include those exposed to virus and those who fear they have been exposed to virus. The potential devastating impact of Zika on the fetus, absent efficient diagnostic tools to foster early detection, will likely lead to an increased utilization of both indirect screening (ultrasound and perhaps MRI) and direct testing (amniocentesis or fetal blood sampling for PCR testing). It may well also alter the national perception of the appropriateness and timing of abortion should an infected or potentially infected fetus be discovered.

Aziz: If Zika virus were endemic in the U.S., this would have a significant impact on the field of reproductive medicine, at least until more data was obtained regarding congenital infection, including the risk of fetal transmission and the risk of fetal/neonatal sequelae in the setting of congenital infection. Zika would impact numerous aspects, including general prenatal counseling, increased maternal prenatal laboratory testing during the pregnancy, and fetal surveillance with additional ultrasound imaging through the pregnancy.

Penzias: The CDC and WHO have been superb in communicating the status and risk of Zika. Kudos to them. This has allowed us to counsel our patients adequately and accurately. The impact will be our incorporation of Zika education, preparation, and precautions into the fabric of our daily interactions with patients.

Regional Risks

Romero: It will likely be a routine part of preconception counseling and prenatal care in the states that border the Gulf of Mexico, and in discussion with patients who live elsewhere but intend to travel to areas where the virus is considered endemic during pregnancy or while contemplating conception. The CDC guidelines are frequently updated and very helpful, as is their 1-800 hotline.

Liu: Endemic areas such as the Southern states will have a recognizable decrease in birth rates. For pregnant women infected with Zika and having a malformed fetus, the option of abortion will become an issue.

Jumping the Gun

Blackwell: It is entirely unclear and would be wholly speculative at this point in time. Certainly the public and our patients are going to have a very heightened concern and anxiety until there is more scientific data to provide guidance.

Thorp: The \$1.8 billion the President has requested for Zika research is greater than the entire budget of NICHD. I fear that the panic or fear around Zika will absorb all the dollars from addressing ignorance on important disorders like preterm birth and autism. My concern is diversion of attention and resources for the condition we are in a dither over rather than working out the basic epidemiology of this viral illness.

View the story online: [Click here](#)

New AbbVie hepatitis C regimen shows high cure rates: studies

Bill Berkrot, Reuters | 4.16

An experimental once-daily combination hepatitis C treatment being developed by AbbVie Inc demonstrated very high cure rates across a wide range of disease genotypes, according to data presented on Saturday, likely giving the company a more competitive product if approved.

Cure rates of 97 percent to 100 percent over either eight or 12 weeks of treatment were achieved in the clinical trials with the one pill, once-a-day combination of ABT-493 and ABT-530, which use different methods to block virus replication.

The combination would provide greater convenience for a wider variety of patients than AbbVie's Viekira Pak, improving chances of making inroads into the market domination currently enjoyed by Gilead Sciences Inc.

Viekira Pak, which is approved for genotype 1, the most common form of the serious liver disease in the United States, consists of four drugs and involves taking three pills in the morning and one in the evening. It currently has only about 5 percent of the market, with Gilead owning about 90 percent.

Another AbbVie product treats genotype 4, which is most common in Egypt and other parts of Africa.

The new one pill combination proved effective across the spectrum of genotypes 1-6 in the midstage studies presented at a European liver disease meeting in Barcelona.

In patients without cirrhosis who were not helped by an older regimen, 97 percent of those with genotype 1 and 98 percent of those with genotype 2 had no detectable hepatitis C virus in the blood 12 weeks after completing eight weeks of therapy, which is considered cured.

Patients with genotype 3 and no cirrhosis receiving treatment for the first time had a 97 percent cure rate with eight weeks of therapy.

Cure rates of 100 percent were achieved with 12 weeks of treatment in genotype 3 patients with cirrhosis, and in non-cirrhotic patients with genotypes 4, 5 and 6.

"These new data show us the potential of ABT-493 and ABT-530 in genotype 3 patients new to therapy even with the added complication of compensated cirrhosis," Dr. Paul Kwo, one of the lead investigators and professor of medicine at the Indiana University School of Medicine, said in a statement.

Cirrhosis, a form of severe scarring, is an indication of advanced disease that can lead to diminished liver function or liver failure.

The most common side effects were fatigue, headache, nausea and diarrhea, the company reported.

View the story online: [Click here](#)

Current hepatitis C virus testing guidelines miss too many cases, study suggest

As reported by Science Daily | 4.13

A review of blood samples for nearly 5,000 patients seen at The Johns Hopkins Hospital Emergency Department suggests that federal guidelines for hepatitis C virus (HCV) screening may be missing up to a quarter of all cases and argues for updated universal screening.

A report on the study is published online ahead of print in the journal *Clinical Infectious Diseases*.

Currently, the U.S. Centers for Disease Control and Prevention (CDC) recommends one-time HCV testing for all adults born between 1945 and 1965, or for those with risk factors such as injection drug use, HIV or use of clotting factors. But up to one-quarter of infections could remain undiagnosed, according to results of the new study, and the authors say that universal one-time testing of all U.S. adults seeking care at inner-city emergency rooms might identify many more people who have the virus, getting them into management and treatment. Better screening would also reduce the risk of spreading the infection to others.

In November 2015, The Johns Hopkins Hospital expanded its testing for HCV to all eligible Emergency Department adults 18 and older who have their blood drawn as part of routine clinical care and are not known to be HCV antibody-positive. Johns Hopkins Bayview Medical Center adopted this expanded testing protocol in February 2016. The Johns Hopkins team specifically found that nearly 14 percent of patients among the 5,000 tested positive for HCV, one-third of whom were unaware they were infected.

"Hepatitis C has a very long clinical arc, so if you get infected, you may not have obvious signs of illness for five to 10 years. Ultimately, it eats away at the liver in many people and can cause liver cancer," says

senior study author Thomas C. Quinn, M.D., professor of medicine and pathology at the Johns Hopkins University School of Medicine. "This is an infection that can now be cured if detected early, rendering people noninfectious and thereby preventing the dire consequences that are associated with the virus. However, we found a large proportion of undocumented, undiagnosed hepatitis C infection in the population attending this ED."

Many people with risk factors like injection drug use don't disclose their risk information to emergency department staff, so universal testing, "in addition to the CDC recommendations, is the only way to identify as many HCV infections as possible," adds lead study author Yu-Hsiang Hsieh, Ph.D., an associate professor in Johns Hopkins' Department of Emergency Medicine.

"We found high prevalence rates of HCV even in young adult patients, suggesting we need to expand testing beyond the baby boomer cohort," Hsieh says. "Urban EDs should consider expanding CDC HCV testing recommendations to permit more robust identification of patients with unknown HCV status."

For the study, the researchers examined blood samples from 4,713 patients older than 17 presenting to The Johns Hopkins Hospital's Emergency Department between June and August 2013. Of these patients, 652 (13.8 percent) were HCV antibody-positive, meaning they either had HCV currently or at a prior time, and 204 (31.3 percent) of those who tested positive had undocumented HCV infection. Patients born between 1945 and 1965 had an HCV prevalence of about 25 percent compared with adults born outside this range, who had an HCV prevalence of 7 percent. These baby boomers also had a higher prevalence of undocumented HCV -- about 7 percent versus 2.6 percent in other adults tested. Non-African-American men and women as young as 18 to 34 (born between 1979 and 1995) had a high HCV prevalence of up to 7.6 percent.

Among the 204 Emergency Department patients with undocumented HCV infection, 128 (63 percent) were in the 1945 to 1965 birth cohort, 45 (22 percent) were injection drug users and 10 (5 percent) were known to be infected with HIV. Further assessments by the researchers found that 99 (49 percent) would be diagnosed based on birth cohort testing alone, with an additional 54 (26 percent) identified based on modified CDC risk-based testing (based on injection drug use or known HIV status).

"Had we established an emergency room HCV testing program with just these guidelines, 51 patients (25 percent) with undocumented HCV would not have been identified during our study period," Hsieh says. "Given an estimated 7,727 unique ED patients with HCV infection in a one-year period, birth cohort testing would identify 1,815 undocumented infections, but universal testing would identify an additional 526 cases."

The results also underscore the need for federal and state HCV management and treatment resources to support emergency departments and HCV patients, Quinn and Hsieh say. "It sounds easy to do HCV testing for every eligible patient, but it takes a lot of effort," Hsieh says.

In the near future, the investigators hope to examine the cost-effectiveness of different HCV screening approaches in the emergency department setting, including universal testing and CDC-recommended birth cohort testing. But with a projected 3.2 million people infected with HCV in the U.S. alone, it's critical for all of these patients to be identified, treated and cured, say the researchers.

"It's not often that we get to say we can cure a medical condition," says Hsieh. "So when we can, we should implement protocols that allow us to easily identify those in need."

Journal reference:

Yu-Hsiang Hsieh, Richard E. Rothman, Oliver B. Laeyendecker, Gabor D. Kelen, Ama Avornu, Eshan U. Patel, Jim Kim, Risha Irvin, David L. Thomas, Thomas C. Quinn. Evaluation of the Centers for Disease Control and Prevention Recommendations for Hepatitis C Virus Testing in an Urban Emergency Department. *Clinical Infectious Diseases*, 2016; 62 (9): 1059 DOI: [10.1093/cid/ciw074](https://doi.org/10.1093/cid/ciw074)

View the story online: [Click here](#)

Peru reports first case of sexually transmitted Zika virus

As reported by Reuters | 4.16

Peruvian health authorities on Saturday reported the first case of the Zika virus having been sexually transmitted in the country, after a resident contracted the disease while traveling in Venezuela and then infected his wife once back in Peru.

Zika has been linked to thousands of suspected cases of microcephaly, a rare birth defect, in Brazil.

Health Minister Anibal Velasquez said a 32-year-old woman was infected with the virus after having sexual intercourse with her 39 year-old husband who had contracted the disease in Monagas, Venezuela.

This is the seventh case of Zika virus detected in Peru, and the first case of it being sexually transmitted in the country, the Health Ministry said.

Traces of the Zika virus were found in the semen and both wife and husband are in recovery, it added.

U.S. health officials have concluded that Zika infections in pregnant women can cause microcephaly, a birth defect marked by small head size that can lead to severe developmental problems in babies.

The World Health Organization has said there is strong scientific consensus that Zika can also cause Guillain-Barre, a rare neurological syndrome that causes temporary paralysis in adults.

The connection between Zika and microcephaly first came to light last fall in Brazil, which has now confirmed more than 1,100 cases of microcephaly that it considers to be related to Zika infections in the mothers.

View the story online: [Click here](#)

Scientific Papers/Conference Abstracts

HIV Transmission Risk Persists During the First 6 Months of Antiretroviral Therapy.

Mujugira A, Celum C, Coombs RW, et al. *JAIDS* 2016; [Epub ahead of print]

Objective:

Combination antiretroviral therapy (ART) decreases the risk of sexual HIV transmission by suppressing blood and genital HIV RNA concentrations. However, HIV transmission risk may persist prior to achieving complete viral suppression.

Design:

Prospective cohort study.

Methods:

Using data from the Partners PrEP Study, a prospective study of 4747 heterosexual HIV-serodiscordant couples in Kenya and Uganda, we examined multiple markers of HIV transmission risk during the first months after ART initiation: time to viral suppression in blood, persistence of HIV RNA in genital specimens, sexual risk behavior, pregnancy incidence, and HIV transmission using survival analysis and GEE logistic regression.

Results:

The cumulative probabilities of achieving blood viral suppression (<80 copies/ml) 3, 6 and 9-months after ART initiation were 65.3%, 84.8% and 89.1%, respectively. Endocervical and seminal HIV RNA were detectable in 12% and 21% of samples obtained within 6-months of ART. Pregnancy incidence was 8.8 per 100 person-years during the first 6-months of ART, and sex unprotected by condoms was reported at 10.5% of visits. Among initially uninfected partners, HIV incidence before ART was 2.08 per 100 person-years (55 infections; 2644 person-years), 1.79 for 0-6 months after ART initiation (3 infections; 168 person-years), and 0.00 with >6 months of ART (0 infections; 167 person-years).

Conclusions:

Residual HIV transmission risk persists during the first 6-months of ART, with incomplete viral suppression in blood and genital compartments. For HIV-serodiscordant couples in which the infected partner starts ART, other prevention options are needed, such as pre-exposure prophylaxis, until viral suppression is achieved.

View the paper online: [Abstract](#)

Correlates of Antiretroviral Therapy Adherence among HIV-Infected Older Adults

McCoy K, Waldrop-Valverde D, Balderson BH, et al. *Journal of the International Association of Providers of AIDS Care* 2016; [Epub ahead of print]

Background:

Despite the success of antiretroviral therapy (ART), HIV-infected older African Americans experience higher mortality rates compared to their white counterparts. This disparity may be partly attributable to the differences in ART adherence by different racial and gender groups. The purpose of this study was to describe demographic, psychosocial, and HIV disease-related factors that influence ART adherence and to determine whether race and gender impact ART adherence among HIV-infected adults aged 50 years and older.

Methods:

This descriptive study involved a secondary analysis of baseline data from 426 participants in “PRIME,” a telephone-based ART adherence and quality-of-life intervention trial. Logistic regression was used to examine the association between independent variables and ART adherence.

Results:

Higher annual income and increased self-efficacy were associated with being $\geq 95\%$ ART adherent. Race and gender were not associated with ART adherence.

Conclusion: These findings indicated that improvements in self-efficacy for taking ART may be an effective strategy to improve adherence regardless of race or gender.

View the paper online: [Abstract](#)

Trend Analyses of Users of a Syringe Exchange Program in Philadelphia, Pennsylvania: 1999–2014

Maurer LA, Bass SB, Ye D, et al. *AIDS and Behavior* 2016; [Epub ahead of print]

Abstract:

This study examines trends of injection drug users’ (IDUs) use of a Philadelphia, Pennsylvania, syringe exchange program (SEP) from 1999 to 2014, including changes in demographics, drug use, substance abuse treatment, geographic indicators, and SEP use. Prevention Point Philadelphia’s SEP registration data were analyzed using linear regression, Pearson’s Chi square, and t-tests. Over time new SEP registrants have become younger, more racially diverse, and geographically more concentrated in specific areas of the city, corresponding to urban demographic shifts. The number of new registrants per year has decreased, however syringes exchanged have increased. Gentrification, cultural norms, and changes in risk perception are believed to have contributed to the changes in SEP registration. Demographic changes indicate outreach strategies for IDUs may need adjusting to address unique barriers for younger, more racially diverse users. Implications for SEPs are discussed, including policy and continued ability to address current public health threats.

View the paper online: [Abstract](#)

Evolution of changes in cognitive function after the initiation of antiretroviral therapy

Mora Peris B, Stevens E, Ferretti F, et al. *AIDS Research and Therapy* 2016;13:20 DOI: 10.1186/s12981-016-0104-0

Background

Cognitive function is reported to improve after the initiation of combination antiretroviral therapy (cART). Data on the evolution of such changes are limited. We assessed the dynamics of changes in cognitive parameters, in HIV-positive subjects initiating cART.

Methods

Cognitive function in seven domains was evaluated for HIV-infected patients without clinically significant cognitive impairment prior to the initiation of cART, and 24 and 48 weeks after. Cognitive scores were transformed using standardised z-scores according to the pooled baseline standard deviation. Global, speed, and accuracy composite z-scores were calculated with changes calculated using a paired t test.

Results

In 14 subjects, change in global cognitive z-scores from baseline was by 0.08 at week 24 ($p = 0.59$) and 0.15 at week 48 ($p = 0.43$). Change in composite speed and accuracy z-scores from baseline at weeks 24/48 were 0.07/0.05 ($p = 0.45/0.82$) and 0.13/0.23 ($p = 0.47/0.45$), respectively. In two of the cognitive domains assessing speed (learning and monitoring time), a continued improvement from baseline to weeks 24 and 48 was observed (changes of 0.06–0.08 and 0.10–0.19, respectively), whereas in two domains (detection and identification) an initial improvement at week 24 (changes of –0.10 and 0.04 from baseline, respectively) was followed by a deterioration in score at week 48 (changes of –0.12 and –0.08 from baseline, respectively). None of these changes were statistically significant.

Conclusions

A trend for improvement in cognitive function was observed in naïve HIV-positive patients starting cART. The dynamics of this improvement differed both between cognitive domains and the time-points assessed.

View the paper online: [Full paper](#)

Resources, Webinars, & Announcements

2016 National Ryan White Conference Deadlines Approaching

Blog.aids.gov

The April 29 deadline for submitting abstracts for a workshop or poster at the **2016 National Ryan White Conference on HIV Care and Treatment** is quickly approaching. The conference will take place August 23-26 in Washington, DC. Visit RyanWhite2016.org to learn more about the abstract submission process.

You can also learn more about the conference as well as register [online](#). Space is limited. Registration closes on July 25.

Stay on top of all National Conference news and important updates by following us on Twitter at [@RyanWhite2016](https://twitter.com/RyanWhite2016)

Engaging Faith-Based Groups to Address Viral Hepatitis—Archived Webinar Materials Now Available!

Blog.aids.gov

Hepatitis B and C affect as many as 2.2 million and 5.3 million people, respectively, from all walks of life and across the United States. To be successful, our national response to viral hepatitis requires that all parts of society participate, including faith communities. Recently, the Department of Health and Human Services (HHS) Office of HIV/AIDS and Infectious Disease Policy (OHAIDP) partnered with the HHS Center for Faith-based and Neighborhood Partnerships (Partnership Center) to sponsor a webinar on the important roles of faith communities in the national response to viral hepatitis.

This webinar is part of continued efforts to increase awareness of viral hepatitis, promote vaccination and testing, and to share effective strategies and tools for community-level outreach, including the Partnership Center's newly developed [Health Ministers Guide to Viral Hepatitis: The Silent Epidemic](#) [PDF, 801 KB].

The [webinar](#), moderated by **Kimberly Konkell**, MSW, Associate Director for Health at the Partnership Center, featured brief presentations from Federal and community partners who highlighted key areas of need and opportunities to address viral hepatitis within faith communities.

Corinna Dan, RN, MPH, Viral Hepatitis Policy Advisor at OHAIDP, provided an overview of the [Action Plan for the Prevention, Care and Treatment of Viral Hepatitis](#) (Action Plan) goals of increasing diagnosis rates of hepatitis B (HBV) and hepatitis C (HCV) viruses, reduction of new HCV infections, and the elimination of perinatal HBV transmission. Ms. Dan also highlighted the troubling data showing that new HCV infections increased 150% between 2010-2013, underscoring the need for comprehensive approaches to identify those at risk for, or living with viral hepatitis.

Michelle Moses-Eisenstein, MPH, Public Health Analyst at OHAIDP, discussed the unique opportunities through which faith leaders can join the efforts to eliminate viral hepatitis and highlighted key resources such as the Centers for Disease Control and Prevention (CDC)'s Know More Hepatitis [campaign](#) and the 5-minute viral hepatitis risk [assessment](#). The dynamic relationships that exist within faith-based communities may promote effective, destigmatized, and supportive conversations that can encourage individuals to get tested.

Cary L. Goodman, Executive Administrator & Program Coordinator at [The Balm in Gilead](#), described his organization's work to address viral hepatitis health disparities by engaging African-American faith communities. Mr. Goodman detailed several activities conducted in support of addressing viral hepatitis, including an October 2015 Senate briefing on HCV and African-American faith leaders, and a faith-based Town Hall promoting HCV awareness.

Ivonne Fuller Cameron, MPH, NRPP, President & CEO of [Hepatitis Foundation International](#) (HFI), discussed the ways in which faith communities can be critical to engaging hard-to-reach populations who are at risk for viral hepatitis. Viral hepatitis infection disproportionately impacts several groups, including: racial/ethnic minorities, homeless persons, persons with substance use disorders, and those living with HIV/AIDS. Many of these groups also experience other issues (e.g., trauma, incarceration, stigma, socio-economic disadvantages) that may pose as additional risk factors for viral hepatitis, as well as barriers to care and improved health outcomes.

Mollie Jackson-Woodson, an HFI Patient Ambassador, shared her personal story of living with chronic HCV infection. Ms. Jackson-Woodson candidly described her journey to improved health, through addressing a substance use disorder, maintaining engagement with clinical specialists, and remaining aware of her health status. She also shared that stigmatization of common risk factors for viral hepatitis (such as intravenous drug use) and poor access to health care must both be addressed in order to effectively improve outcomes for those with viral hepatitis.

While viral hepatitis is associated with significant health consequences such as cirrhosis, liver cancer, and liver-related death, we now have more resources and opportunities available than ever before to progress towards eliminating viral hepatitis. The Affordable Care Act has increased access to healthcare

coverage for millions of individuals, and preventive hepatitis vaccinations (for hepatitis A and hepatitis B) and screenings for hepatitis B and hepatitis C infection are now covered without cost-sharing. Newly available HCV treatments have the potential to cure nearly all individuals. Ensuring that more individuals are diagnosed and linked into care remains important steps to improving health outcomes for the millions of Americans living with chronic viral hepatitis. Faith leaders are positioned to help lead our national response to viral hepatitis by raising awareness within their communities, connecting people to viral hepatitis resources and services, and helping to reduce the barriers people face in addressing their health needs.

The following webinar resources are [available](#) for download:

- Archived webinar
- Webinar slides
- Webinar transcript

Please visit the [Partnership Center](#) for more information and resources for faith leaders to support viral hepatitis efforts.

FINAL REMINDER: 2016 STD Prevention Conference Abstract Deadline is April 25

CDC

The deadline to submit your abstract for the 2016 STD Prevention Conference is rapidly approaching. **Abstracts must be submitted no later than Monday, April 25, 2016 at 11:59 PM, PDT.** This deadline is firm and no extensions will be granted, so don't delay and [submit your abstract](#) before time is up!

Don't forget to use [this new resource](#) for help writing your abstract.

We will continue to update the [conference website](#) with key information to help you plan your attendance.

Job/Internship Postings

Supervising Communicable Disease Investigator Vacancy - San Diego County

Organization: San Diego County
Location: San Diego, CA
Salary: \$57,969.60 - \$71,260.80 Annually

Public Health Services has an immediate opening for Supervising Communicable Disease Investigator. Incumbent will be responsible for planning, supervising, and coordinating the work of Communicable Disease Investigators and other staff members engaged in communicable disease investigations, clinical counseling services.

For a complete job description including essential functions, required certifications, working conditions, essential physical characteristics, etc., please click [here](#).

REQUIRED EDUCATION AND/OR EXPERIENCE

1. A bachelor's degree from an accredited U.S. college or university, or certified foreign studies equivalency in a behavioral, social, natural science, or a closely related field; AND, at least three (3) years of investigative experience in enforcement of communicable disease laws, rules, and regulations in a position comparable to Communicable Disease Investigator in the County of San Diego; OR,
2. Any combination of higher education and investigative experience in the enforcement of communicable disease laws, rules, and regulations in a position comparable to Communicable Disease Investigator in the County of San Diego, totaling seven (7) years.

NOTE: A State of California Phlebotomy License is required within six (6) months of employment.

EVALUATION

Qualified applicants will be placed on a twelve (12) month employment list based on scores received during the evaluation of information contained in their employment and supplemental application. Please ensure that all information is complete and accurate as the responses you provide on the supplemental application form will be reviewed using automated evaluation system. If you are successful in the initial screening process your application will be reviewed individually to confirm that the information you provided is accurate and qualifying.

NOTES

Reasonable accommodation may be made to enable an individual with qualified disabilities to perform the essential functions of a job, on a case-by-case basis.

The County of San Diego and its employees embrace the Live Well San Diego vision: A region that is Building Better Health, Living Safely and Thriving. Click here for more information www.livewellsd.org.

Under California Government Code Sections 3100 - 3109, public employees are designated as disaster service workers. The term "public employees" includes all persons employed by the state or any county, city, state agency, or public district. Disaster service workers are required to participate in such disaster service activities as may be assigned to them by their employer or by law.

For more information: [Click here](#)

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Archives of previous STD Updates can be found [here](#). To unsubscribe or add colleagues' names, email aaron.kavanaugh@cdphc.a.gov. If you have an item related to STD/HIV prevention which you would like included, please send. No bibliographic questions please; all materials are compiled from outside sources and links are provided. No endorsement should be implied! Note: Some words may have been palced in [brackets] or replaced with blanks (___) or asterisks (*) in order to avoid filtering by email inboxes.

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