State of Alaska Epidemiology **Bulletin**

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Gonorrhea Outbreak Update — Alaska, 2019 and Recommendations for Care

Background

Alaska has been experiencing a gonorrhea (GC) outbreak since October 2017 and our 2018 GC rate was the second highest in the nation.[1,2] From 2009 to 2018, the national rate of reported GC cases increased by 82.6% and the state rate nearly doubled.[1]

The Centers for Disease Prevention and Control (CDC) provided guidance for scenarios when in-person clinical exams are limited during the COVID-19 pandemic.[3] This *Bulletin* provides an update on the GC outbreak and a summary of CDC's guidance for alternative STD services during the pandemic.

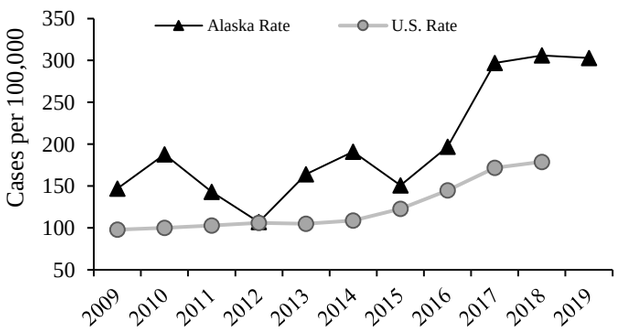
Methods

Case data were reviewed from the Section of Epidemiology's (SOE) Patient Reporting Investigation Surveillance Manager (PRISM) and the National Electronic Disease Surveillance Base System (NBS). Population data were obtained from the Alaska Department of Labor and Workforce Development.

Results

In 2019, 2,215 GC cases were reported to SOE; the incidence rate was 303 cases per 100,000 persons (a 1% decrease from the 2018 rate; Figure).

Figure. Gonorrhea Rate by Year — Alaska and the United States, 2009–2019*



**Note: the 2019 U.S. rate is not yet available.*

Of the 2,215 cases:

- 1,128 (51%) were in females, 79 (7%) of whom were also diagnosed with pelvic inflammatory disease (PID);
- the age range was 14–83 years;
- rates by age were highest in persons aged 20–24 years and 25–29 years (979 and 834 per 100,000 population, respectively);
- rates by race were highest in American Indian/Alaska Native persons, followed by Black/African American, and Native Hawaiian/Pacific Islanders, (981, 924, and 360, cases per 100,000 population, respectively); and
- rates by region were highest in the Northern, Anchorage/Mat-Su, and Southwest regions (791, 358, 320 cases per 100,000 population, respectively).

Discussion

Alaska's GC outbreak is ongoing and is disproportionately impacting racial/ethnic minority groups. In 2019, the HIV/STD Program's response to the ongoing syphilis outbreak and years of reductions in SOA Section of Public Health Nursing capacity have limited the ability to provide contact tracing for reported GC cases. Providers now play a critical role in counseling infected persons of the need for their sex partners to be tested and treated, and increasing the use of EPT (expedited partner therapy). EPT is characterized by the clinical practice of treating the sex partners of persons diagnosed with GC or chlamydia without the health care provider first examining the partner. Implementation of EPT can be either patient-delivered partner therapy, where patients deliver medications or prescriptions to their sexual partner(s), or prescriptive arrangements with cooperating pharmacies. EPT represents an additional strategy for partner management that does not replace other strategies such as provider-assisted referral, if available. EPT is a legal treatment option in Alaska.[4]

During the COVID-19 pandemic, CDC's treatment guidance includes increased use of syndromic management and EPT when facility-based services and in-person patient-clinician contact is limited. Interim treatment recommendations are based on patient symptoms when in-person clinical exams are not feasible.[3]

Recommendations

1. Routinely elicit a thorough sexual history on all sexually-active patients that includes questions about genital, oral, and anal sexual activity.
2. Test genital, pharyngeal, and anal specimens, as appropriate.[5]
3. When testing for GC, also test for other sexually transmitted diseases, including chlamydia, syphilis, HIV, and HCV.
4. Promptly treat GC patients and their sex partner(s) with ceftriaxone 250 mg IM **PLUS** azithromycin 1 g PO, each in a single dose on the same day.[6]
5. In the absence of in-person clinical care, treat patients diagnosed with GC based on symptoms and presumptively treat their sex partner(s) via EPT:
   - Cefixime 800 mg PO **PLUS** azithromycin 1 g PO each in a single dose on the same day **OR**
   - Cefpodoxime 400 mg PO q 12 hours X 2 doses **PLUS** azithromycin 1 g PO.[3]
6. If treated with alternative oral regimens, counsel patients to seek follow-up in 5–7 days if symptoms do not improve and to be tested for STDs/HIV once in-person clinical care resumes.[3]
7. Inform GC patients to notify their sexual partners of their exposure risk and encourage them to get tested and treated, and about the high risk of re-infection through engaging in sexual contact with untreated partners.
8. Educate patients about risk-reduction techniques, such as reducing their number of sex partners, and using latex condoms correctly during every sexual encounter.
9. Re-test patients for re-infection 3 months after treatment.
10. Report GC cases and treatment to SOE within 2 working days by fax to 561-4239. Report forms are available at: http://dhss.alaska.gov/dph/Epi/Documents/pubs/conditions/frmSTD.pdf

References

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