

Bureau of Sexually Transmitted Disease Control

Annual Report 2004



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THE NEW YORK CITY DEPARTMENT
of HEALTH and MENTAL HYGIENE

Michael R. Bloomberg, Mayor

Thomas R. Frieden, M.D., M.P.H., Commissioner

How to Report Sexually Transmitted Diseases

Prompt reporting of all diseases and conditions is important. Contact the New York City Department of Health and Mental Hygiene at 1 (866) NYC DOH1 by telephone, or electronically at www.nyc.gov/health/nycmed to report the following sexually transmitted diseases:

- Chancroid
- Chlamydia trachomatis infections (genitourinary and perinatal)
- Gonococcal infection (gonorrhea)
- Granuloma inguinale (donovanosis)
- Lymphogranuloma venereum
- Syphilis
- Urethritis, non-gonococcal

Reports must be made within 24 hours of clinical examinations or laboratory findings that indicate the presumptive presence of any of the abovementioned diseases. Include the:

- Full name of the patient, and if known, the date of birth and address.
- Name and address of the physician or other authorized person who submitted the specimen.
- Name and address of the laboratory that performed the test.
- Date the test or tests results were first available.
- Name(s) of test or tests performed, and the site of specimen collection.
- Positive or reactive results (including titer of the serologic test for syphilis if quantitative test was performed).

Contact us

For more information about the Bureau of Sexually Transmitted Disease Control, call 311.

Image #836: Histopathology showing *Treponema pallidum* spirochetes in testis of experimentally infected rabbit. Modified Steiner silver stain. Used with permission from the Centers for Disease Control and Prevention Public Health Image Library and Dr. Edwin P. Ewing, Jr.

Our Mission

The Bureau of Sexually Transmitted Disease Control's primary mission is to prevent, control, and monitor sexually transmitted infections and their sequelae, and in the process, to promote sexual health among New Yorkers.

To achieve this mission, the Bureau:

- ▣ Provides direct clinical services and partner services;*
- ▣ Monitors existing and emerging disease trends;*
- ▣ Conducts research about risk behaviors, treatment, and prevention;*
- ▣ Collaborates with community groups, private providers, and other agencies;*
- ▣ Performs outreach, including educational programs.*

Our Core Activities

Prevention

- ▣ Promoting sexual health behaviors that prevent Sexually Transmitted Diseases (STDs), including abstinence, limiting the number of sex partners, condom use and vaccinations as appropriate.
- ▣ Disseminating information to individuals at risk through media campaigns and partnerships with community-based organizations and other agencies.

Control

- ▣ Controlling the spread of STDs and removing barriers to care by offering a range of educational and clinical programs for health care providers and the public;

diagnostic, counseling, partner notification, and referral services for individuals exposed to HIV and other STDs; emergency contraception; vaccinations for hepatitis A and B; and screening for hepatitis C.

Surveillance

- ▣ Using mandated provider and laboratory reports, sentinel site and behavioral surveillance, and data from epidemiologic investigations to monitor trends in disease and disease determinants.
- ▣ Continuously improving the integrity and accuracy of data to gain a clearer understanding of disease trends, prevalent sexual attitudes and behaviors.

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Letter from the Commissioner

Dear Fellow New Yorker,

Sexually transmitted diseases affect tens of thousands of New Yorkers each year. They are preventable, and many can be treated. We have continued to make progress in improving the sexual health of New Yorkers, but there are areas where we need to do much better.

In general, STDs are more prevalent among men and women in our three District Public Health Office Neighborhoods (East and Central Harlem, North and Central Brooklyn, and the South Bronx), and among men in Chelsea.

Gonorrhea and chlamydia disproportionately affect adolescents, women, and African American and Hispanic populations. Although the number of gonorrhea cases is declining overall, the number of chlamydia cases remains unchanged. Syphilis cases continue to increase among men who have sex with men, however, the rate of increase has slowed somewhat.

All New Yorkers should know how to prevent STDs, and that free, confidential testing and treatment are available at Health Department STD clinics. Anyone can receive services free of charge, without the knowledge or consent of parents or spouses. No one will ask any questions about immigration status. And, if needed, we can notify your partners on your behalf without disclosing your identity.

I commend our Bureau of STD Control for their continuing efforts to promote sexual health among New Yorkers.

Sincerely,



*Thomas R. Frieden, MD, MPH
Commissioner*

Executive Summary

In 2004, the Bureau of Sexually Transmitted Disease Control continued to make progress in improving the sexual health of New Yorkers. It is an ongoing challenge, requiring close cooperation and collaboration between the Bureau's public health professionals, the medical community, the individuals we serve, and the community-based organizations which represent them.

Our approach is multi-faceted. In addition to providing direct clinical and partner services throughout the City's five boroughs, we are committed to building awareness of both risk factors and safer sex practices through shared data, regular communication, and a range of educational initiatives. Improvements in data gathering are also helping us respond faster and more accurately to disease trends and sexual attitudes and behaviors.

The 2004 report sets forth key aspects of STD Control's program, particularly as it focuses on the three major STDs – syphilis, gonorrhea, and chlamydia. This Executive Summary presents an overview of the state of STDs in New York City, and some of our most significant accomplishments for the year. It includes a 5-year table for all reportable STDs to illustrate the shifting nature of the challenges we face. The report also provides information, including tables and figures, that describe our activities for the year.

Key Accomplishments

The Bureau achieved many of its objectives in 2004, introducing a number of new organizational, community-based, and epidemiologic initiatives. Our most significant accomplishments follow and are described in greater detail later in this report:

- Healthy Men’s Night Out, also called “Hot Shots!”, a Bureau-designed initiative to address general wellness among men-who-have-sex-with-men (MSM) as well as syphilis and HIV control. This project brought essential health care services into bars, night clubs, and other non-medical settings. A total of 1,228 individuals benefited from services including HIV and other STD screening; hepatitis, pneumococcal, and influenza immunizations; cholesterol, diabetes, and hypertension screening; tobacco cessation, as well as mental health and substance abuse screening and referrals.
- In line with the Centers for Disease Control’s strategies for preventing HIV¹ the Bureau began using OraQuick rapid HIV-1/2 antibody test. Point-of-care screening for HIV, with results available in less than an hour, eliminates turnaround time for standard laboratory-based HIV testing and accelerates referral for HIV primary care. Testing volume increased by nearly 15% in 2004, and percent of patients receiving their results increased to 85%.
- To increase clinic efficiency and improve the quality of clinical services, the Bureau designed a paperless Electronic Medical Record system. During 2004, we began its use in 2 of our 10 clinics.
- In October 2004, we hired a coordinator to oversee the expansion of electronic laboratory reporting. By year end, we received more than 20% of all gonorrhea and chlamydia case reports electronically.
- To enhance the efficiency and reach of our HIV counseling and testing services, the Bureau developed an attractive pre-test counseling video and booklet entitled (What You Need to Know About an HIV Test), and began using them in all 10 clinic sites. The use of these new tools helped the Bureau increase its HIV testing numbers for the year by 15% with over 38,000 HIV tests conducted.

¹CDC Advancing HIV Prevention New Strategies for a Challenging Epidemic United States MMWR; 2003 329-332

Trends

STDs do not affect all cities, communities, or neighborhoods equally. In New York City, syphilis, gonorrhea, and chlamydia case rates are higher than about half of the large (>200,000 population) cities in the United States. Syphilis cases are primarily concentrated among MSM. Gonorrhea and chlamydia disproportionately affect adolescents, women, and African American and Hispanic populations.

Syphilis case rates continued to increase in New York City in 2004, though the rate of increase (17%) was less than that recorded between 2002 and 2003 (22%). The number of reported cases of gonorrhea fell from 13,468 in 2003 to 10,860 in 2004. Despite an overall drop in gonorrhea cases over the last decade, year-end figures suggested that rates may be increasing among MSM. Case rates for chlamydia, the most commonly reported bacterial infection, continued to rise among men in 2004, but fell among women for the same period. Overall, it appears that cases of chlamydia continued to rise due to more testing among men and better test technology.

Fig. 1 Number of Primary & Secondary Syphilis Cases, by Year and Sex

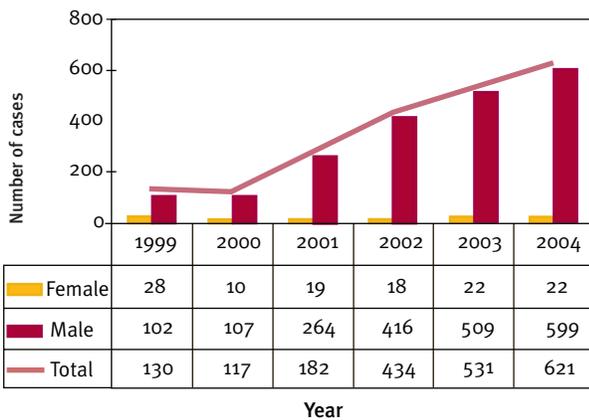


Fig. 2 Number of Gonorrhea Cases, by Year and Sex

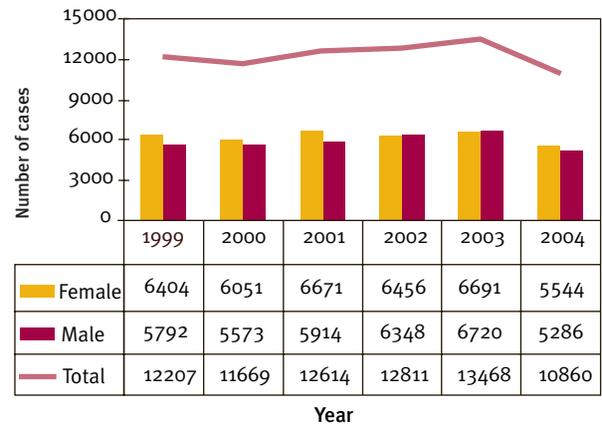
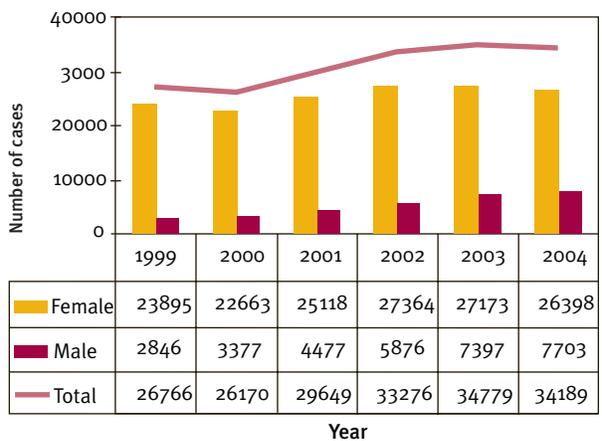


Fig. 3 Number of Chlamydia Cases, by Year and Sex



Our progress in 2004 has been substantial. In 2005 we look forward to completing our implementation of the electronic medical record system and the automation of our surveillance system.

I would like to acknowledge and thank all of our committed Bureau of STD Control staff whose unwavering support allows us to maintain the many facets of this program in the field, at our clinics and in the central office. This continuing support allows us to expand and improve our efforts to prevent and control STDs in New York City and to help improve the quality of life for all New Yorkers.

Susan Blank, M.D., M.P.H.
Assistant Commissioner, Bureau of STD Control

2004 Program Activities

Organizational Developments

During 2004, the Bureau of STD Control made organizational changes to achieve greater efficiency by consolidating functions. Proposed units and their functions include:

- **Epidemiology and Surveillance** ensures cases are reported, receives reports, monitors trends and devises research initiatives and special methods for monitoring cases in response to trends, including outbreaks and other sudden changes.
- **Patient Services and Clinic Operations** manages all patient services at our 10 clinics, including medical, laboratory, pharmacy, patient education, ancillary services, clinic management, and administration.
- **Case Investigation and Partner Services** investigates all cases of early syphilis, and Lymphogranuloma venereum throughout NYC, as well as cases of HIV and fluoroquinolone-resistant gonorrhea diagnosed in our STD clinics. The unit notifies partners identified during case investigations, as well as upon request by infected persons or their providers.
- **Education and Outreach** encompasses activities involving communication, education, and establishing relationships with health care providers, community-based organizations and other important agencies.

In addition to these structural changes, the Bureau also added the Implementation Team, placed within the organizational table to work under the authority of the Deputy Director, and charged with advancing new

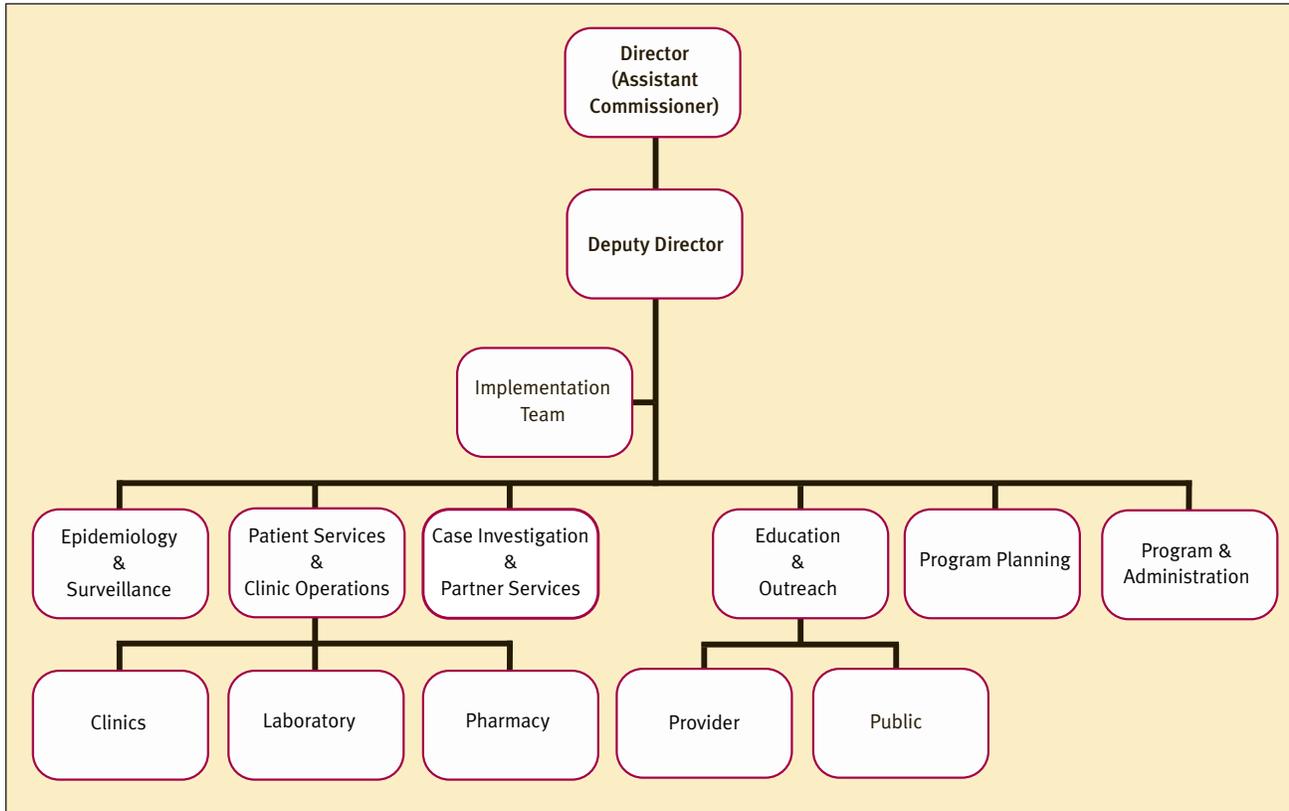
initiatives. A position was added to expand our ability to receive laboratory reports electronically and new positions have been established to oversee case management and partner services. See organization chart on page 6.

Prevention and Control

STDs are preventable. Individual choices, including abstinence, limiting one's number of sexual partners, vaccination when applicable, and the use of barrier protection, strongly limit the spread of these diseases. The Bureau focuses on increasing public awareness of STD frequency, sequelae, and costs. Among our most important tasks is to promote healthy sexual decision-making and behaviors to prevent the acquisition and spread of STDs.

Clinical services, such as screening, diagnosis, and treatment, can identify and treat common curable bacterial STDs. Counseling and education are important in assisting high-risk individuals to modify their sexual behaviors, and partner notification systems help interrupt transmission in local sexual networks. In all cases, education – ensuring that providers and the public have ready access to information and services – is key to prevention.

Bureau of STD Control Organizational Chart



Significant Initiatives

Outreach Activities

Between January and December 2004, the Bureau's Education Unit made more than 1,500 presentations to raise awareness about STDs (including HIV), their impacts on health, and individual prevention strategies to 32,000 people, (1002 for adolescent audiences, 220 for community-based organizations, 70 for drug treatment centers, and more than 300 other presentations).

Through the Centers for Disease Control-funded Syphilis Elimination grant, the Bureau designed an intervention with a field-based holistic approach to the health and wellness of MSM. The intervention, called Healthy Men's Night Out, and branded "Hot Shots!" brought health care services essential to this population into non-medical settings, such as bars and night clubs. Between November 17, 2003 and December 13, 2004, the Bureau coordinated services for 18 "Hot Shot!" events, where a total of 1,228 individuals received at least one service. At each event, on-site services were provided by the

Department of Health and Mental Hygiene (STD screening, hepatitis, pneumococcal, and influenza immunizations); a local hospital (cholesterol, diabetes, and hypertension screening); and community-based organizations serving MSM (HIV testing, tobacco cessation, mental health and substance abuse screening and referrals).

Patient Care Citywide

The Bureau and the Region II STD/HIV Prevention Training Center co-sponsored in-depth training in STD care for 100 primary care providers throughout the region, a syphilis review for 38 providers, and provided 12 grand rounds presentations at hospitals throughout the city. All attendees received the 2002 Treatment Guidelines (a full copy as well as a summary card), STD/HIV reporting forms, information on the syphilis outbreak in New York City, Department health alerts on QRNG (quinolone-resistant *Neisseria gonorrhoea*), LGV (Lymphogranuloma venereum), HIV and information on Prevention Training Center activities. Grand Rounds topics included the following overviews: STDs in General, STDs in Pregnancy, STDs among Adolescents, Syphilis

Management Review, Ulcerative STDs, and STD Epidemiology and its Implications for Clinical Practice.

As part of our adolescent-focused initiatives, the Bureau offered 3-day STD intensive courses for primary care providers in New York City in May, October, and December, as well as in Rochester, New York, in November, 2004.

During the year, the Bureau completed an assessment of provider attitudes and behaviors surrounding STD screening, diagnosis, and partner management (including patient-delivered partner therapy). Information gathered through this process served as a guide in planning for Continuing Medical Education programs for 2005. Key findings of this work revealed that 27% of the providers used patient delivered partner therapy, 54% screened adolescents for Gonorrhea/Chlamydia at least annually, and obstetrician-gynecologists were more likely than other practitioners to screen for STDs.

STD Clinics

To increase efficiency and improve quality, we simplified delivery of the clinical services we provide. This effort included design, programming, installation, training, and implementation of a paperless Electronic Medical Record system. By the end of 2004, this system was developed, tested, and implemented in 2 of our 10 clinics.

To increase accessibility to HIV screening, the Bureau began using the OraQuick rapid HIV-1/2 antibody test which provides results in as little as 20 minutes. Point-of-care screening for HIV eliminates the barrier posed by the turnaround time for standard laboratory-based HIV testing (testing volume increased by nearly 15% in 2004), and makes possible accelerated referral for HIV primary care.

To enhance efficiency in HIV counseling and testing, the Bureau developed a pre-test counseling video and pamphlet, both of which were made available in our 10 clinic sites in English and Spanish, and facilitated the increased HIV testing volume in 2004.

Mid-year the Bureau began collaborating with the Education Development Company on a multi-site CDC sponsored study to develop more compelling patient

messages regarding condom usage. The VOICES/VOCES study has been based at the Central Harlem STD clinic, which enabled the Bureau to add Saturday clinic hours to this clinic in June 2004.

During the summer, to increase the impact of our service delivery, STD Control evaluated health literacy among a representative sample of 645 clinic patients. We found that 42% of clinic patients had a reading capability < 9th grade level. This information was used, and will continue to be used, to guide development of messages and materials for our patients.

As part of a Department commitment to increasing New Yorkers' access to condoms and other prevention tools, late in the year, we changed our policy on condom distribution in STD clinics, which previously provided 3 condoms per person per visit.

Partner Services

To consolidate all case investigations and partner services into a single unit that handles both bacterial STDs and HIV, and to improve coordination of its efforts, the Bureau implemented simplified supervision and streamlined quality assurance practices.

Surveillance and Epidemiology

Ensuring thorough and accurate reporting of STD cases, maintaining and improving the quality and integrity of gathered data, and interpreting and disseminating those data in a timely fashion are the primary goals of the Bureau's surveillance activities.

Since most STDs are asymptomatic and several of the most common ones routinely go unreported, national surveillance systems seriously underestimate their true burden. It is estimated that more than 65 million people in the United States have an STD at any one time. Each year, approximately 19 million new cases of STDs, such as syphilis, gonorrhea, chlamydia, genital herpes, and human papillomavirus, occur at an estimated cost of \$10 billion². Two-thirds of these new cases are diagnosed in people 24 years and younger. Infertility, increased risk for acquiring HIV, and adverse pregnancy outcomes are among the potential, severe lifelong consequences.

² <http://www.nyc.gov/html/doh/html/std/ptc.html>

Significant Initiatives

Infrastructure Development

During the year, the Bureau established sentinel surveillance system for antibiotic-resistant gonorrhea by performing genital gonorrhea cultures at the Fort Greene STD clinic. Although Fort Greene is not part of the national Non-Gonorrhea Isolate Surveillance Program, we share data from this clinic with the Centers for Disease Control and Prevention.

We completed a cross-match of the STD and HIV/AIDS registries to assess the incidence of STDs among HIV-infected persons in NYC. The cross match revealed that among 62,264 persons living with HIV/AIDS in NYC, 1,466 (2.4%) had an incident STI diagnosed during 2001 – 2002 subsequent to an HIV/AIDS diagnosis. The 2 – year cumulative STI incidence was highest among PLWA who were male (2.6%), non-Hispanic white (3.2%), aged 13 – 24 years (8.4%), residents of Manhattan (3.3%) and MSM (4.5%). STI incidence was higher among persons living with HIV (non-AIDS) (4.1%) than among persons with AIDS (1.7%).

Increased Efficiency of Existing Infrastructure

In October, the Bureau hired a coordinator to further develop electronic clinical laboratory reporting activities. By year end, we received more than 20% of all gonorrhea and chlamydia lab-based case reports electronically. Web-based provider reporting also continued to increase. In 2004, 18 providers submitted 1072 reports electronically.

Additional Population-Based Information Gathered Through Citywide Surveys

Sero-epidemiology of Herpes Simplex (types 1 and 2) in New York City gathered from the first ever New York City Health and Nutrition Exam Survey (NYC HANES). Key findings included an HSV-2 prevalence of 28% in the general population; a greater prevalence in females than males; and a greater prevalence among African Americans than in Hispanics, and a greater prevalence among Hispanics than in Whites.

Epidemiology of male sexual behavior and sexual identity based on data from the NYC Community Health Survey. We found a high degree of discordance between self-reported sexual identity and sexual behavior in a

large population-based sample of NYC adult men. Among NYC MSM, an overwhelming majority (73%) identified as heterosexual. Heterosexually-identified MSM were demographically and behaviorally different from their gay-identified counterparts. These findings have substantial implications for the formulation and communication of STD/HIV prevention messages, and highlight the importance of providers taking a non-judgmental sexual history to ascertain sexual behavior, rather than sexual identity.

Using hospital discharge data and review of associated outpatient charts, the Bureau has measured the incidence of neonatal herpes in NYC. Between 1993 and 2003, there were 169 infants 42 days and younger discharged from a NYC hospital with a diagnosis of herpes (range 9 – 22 cases per year). The estimated average incidence is 13.4/100,000 population (range 7.2 – 17.5/100,000 population).

Using surveillance data, a total of 121 cases of possible neurosyphilis (NS) were identified between January 2002 – June 2004; approximately 70% were sampled (n=93) from high-volume syphilis reporters. Charts were obtained on 77 possible cases and among these, 47 (61%) were determined to be cases of NS. These cases are being analyzed as part of a multi-center effort to characterize the incidence of NS among MSM with syphilis.

Research

In collaboration with CDC's Division of STD Prevention Epidemiology and Surveillance Branch, the Bureau participated in a multi-center study of the performance of rapid syphilis diagnostic tests.

Profile of Selected Sexually Transmitted Diseases

Important Trends in Syphilis, Gonorrhea, and Chlamydia

TABLE 1

P&S Syphilis, Gonorrhea, and Chlamydia Cases, by Sex, Age, Race/Ethnicity, and United Hospital Fund Neighborhoods (Number and Rate/100,000) New York City, 2004

	P&S Syphilis		Gonorrhea		Chlamydia	
	N	Rate	N	Rate	N	Rate
Cases^a						
Female	22	0.5	5560	131.9	26469	628.1
Male	599	15.8	5300	139.7	7720	203.5
Age Groups^b						
0 – 9 yrs	0	0.0	26	2.4	66	6.0
10 – 14 yrs	0	0.0	114	21.5	434	81.8
15 – 19 yrs	15	2.9	2468	474.0	10105	1940.9
20 – 24 yrs	65	11.0	3054	517.8	11275	1911.6
25 – 29 yrs	93	13.7	1955	287.2	5852	859.8
30 – 34 yrs	117	17.0	1209	175.9	2881	419.1
35 – 39 yrs	128	19.4	945	143.0	1692	256.0
40 – 44 yrs	117	19.4	552	91.6	891	147.9
45 – 49 yrs	48	9.0	258	48.6	428	80.6
50 – 54 yrs	22	4.6	120	24.9	200	41.6
55 – 59 yrs	9	2.4	42	11.4	90	24.4
60 – 64 yrs	5	1.6	29	9.2	53	16.9
65+ yrs	2	0.2	24	2.6	43	4.6
Race/Ethnicity^c						
Asian/Pacific Islander	16	2.0	125	15.5	1078	134.3
Black	231	11.4	8080	399.7	21532	1065.1
Hispanic	193	8.7	1774	79.8	9391	422.4
Native American/ Alaskan Native	3	17.6	34	194.2	93	521.0
White	151	5.2	628	21.8	1248	43.3
Other Race/Ethnicity	27	44.1	219	361.8	847	1400.1
UHF Neighborhoods^d						
BRONX	63	4.7	2312	174.1	8233	620.1
Crotona	8	4.0	462	231.5	1533	768.3
Fordham	10	4.0	396	158.1	1495	596.8
Kingsbridge	4	4.5	48	53.9	198	222.5
Morrisania	11	5.8	487	256.6	1629	858.5
Mott Haven	8	6.5	232	188.8	924	752.0
Northeast Bronx	7	3.8	317	170.4	1045	561.8
Pelham	14	4.8	320	110.3	1243	428.5
Unknown	1		50		166	

^a Cases in which sex is unknown have been proportionally distributed into both gender categories except UHF

^b Cases with unknown age excluded

^c Cases with unknown race/ethnicity have been proportionally distributed among all categories

^d Cases with unknown residence excluded

TABLE 1 (CONTINUED)

	P&S Syphilis		Gonorrhea		Chlamydia	
	N	Rate	N	Rate	N	Rate
UHF Neighborhoods^d (continued)						
BROOKLYN	134	5.4	4176	169.4	12670	513.9
Bensonhurst	2	1.0	42	21.6	155	79.7
Borough Park	4	1.2	73	22.5	373	115.0
Canarsie	4	2.0	265	134.0	997	504.0
Coney Island	7	2.4	147	51.2	533	185.8
Crown Heights	32	10.1	1260	397.1	3235	1019.6
Downtown Heights	22	10.2	326	151.8	789	367.5
East Flatbush	22	6.9	850	268.4	2821	890.7
East New York	8	4.6	508	292.4	1573	905.5
Greenpoint	9	7.2	100	80.4	264	212.1
Sunset Park	2	1.7	41	34.0	300	249.1
Williamsburg	20	10.3	485	249.6	1400	720.5
Unknown	2		79		230	
MANHATTAN	328	21.4	2495	163.1	6419	419.7
Central Harlem	53	35.1	532	352.1	1180	780.9
Chelsea	82	66.7	342	278.1	475	386.2
East Harlem	20	18.5	265	245.2	691	639.3
Gramercy Park	26	20.9	155	124.5	407	327.0
Greenwich Village	13	15.5	109	130.2	385	459.9
Lower Manhattan	8	25.9	52	168.3	117	378.7
Union Square	31	15.7	215	109.1	595	301.8
Upper East Side	21	9.6	122	55.9	269	123.3
Upper West Side	32	14.4	207	93.2	470	211.6
Washington Heights	29	10.7	334	123.4	1329	491.0
Unknown	13		162		501	
QUEENS	89	4.0	1702	75.9	6186	275.9
Astoria	19	8.6	165	74.7	509	230.4
Bayside	1	1.1	16	18.1	71	80.5
Flushing	2	0.8	64	25.0	310	121.3
Forest Hills	7	2.9	79	32.8	277	115.0
Fresh Meadows	4	4.3	31	33.3	130	139.6
Jamaica	11	3.9	505	176.8	1588	556.1
Rockaway	0	0.0	177	165.8	495	463.8
Southeast Queens	6	2.9	233	114.4	822	403.6
Southwest Queens	9	3.3	149	55.2	649	240.4
West Queens	30	6.3	221	46.3	1043	218.4
Unknown	0		62		292	
STATEN ISLAND	7	1.6	175	39.4	681	153.5
Port Richmond	0	0.0	44	70.1	178	283.5
South Beach	2	1.1	36	20.0	84	46.7
Stapleton	5	4.3	78	67.1	315	271.0
Willowbrook	0	0.0	14	16.5	77	90.8
Unknown	0		3		27	
NEW YORK CITY TOTAL	621	7.8	10860	135.6	34189	426.9

Primary & Secondary (P&S) Syphilis

TABLE 2

P&S Syphilis Cases by Race/Ethnicity and Sex (Number and Rate/100,000 and Median Age), New York City, 2004*

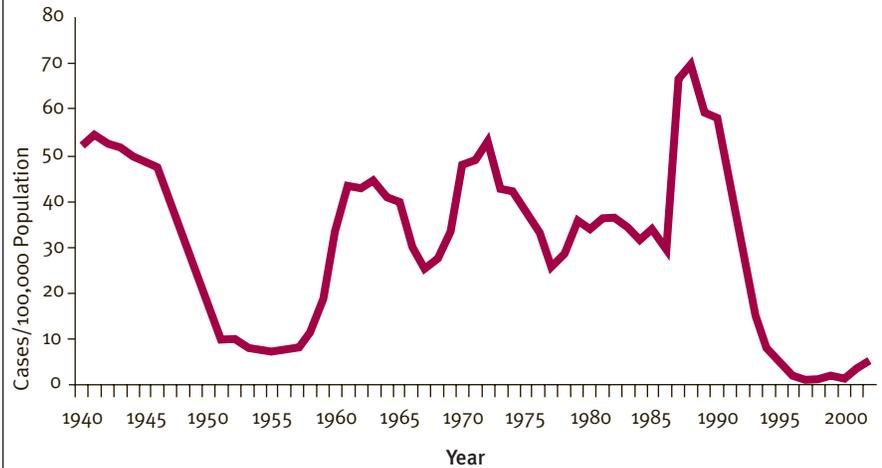
Race/Ethnicity	N	Rate/100,000	Median Age** (years)
Asian/Pacific Islander			
Female	0	0.0	
Male	16	3.9	32
Black			
Female	15	1.3	30
Male	216	24.0	35
Hispanic			
Female	5	0.5	24
Male	188	17.5	36
Native American/Alaskan Native			
Female	0	0.0	
Male	3	37.1	29
White			
Female	2	0.1	37
Male	149	10.8	37
Other Race/Ethnicity			
Female	0	0.0	
Male	27	89.8	36
Total	621	7.8	36

* Cases with unknown sex and race/ethnicity have been proportionally redistributed into the above categories

** Median age calculated based on cases with known age

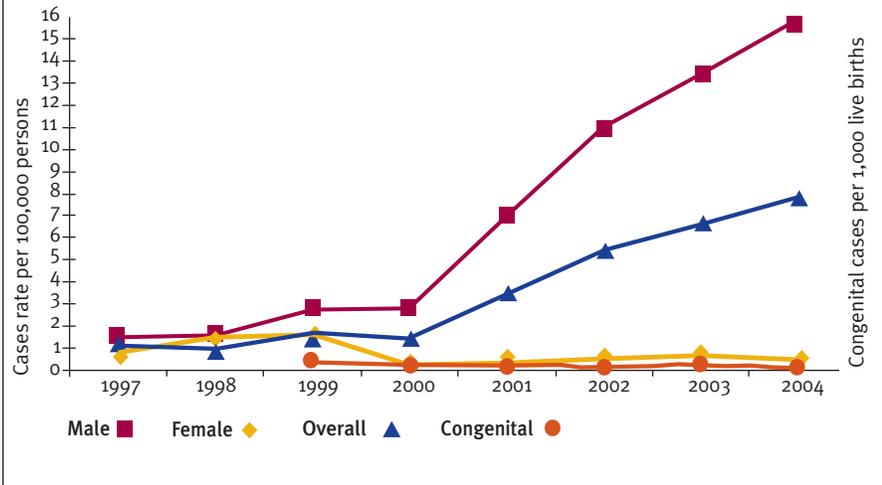
- Overall NYC case rates steadily declined between 1988 and 1998
- Historic peak at 69.3 cases per 100,000 population in 1988

Fig. 4
P&S Syphilis Cases (Rate/100,000), New York City, 1940 – 2004



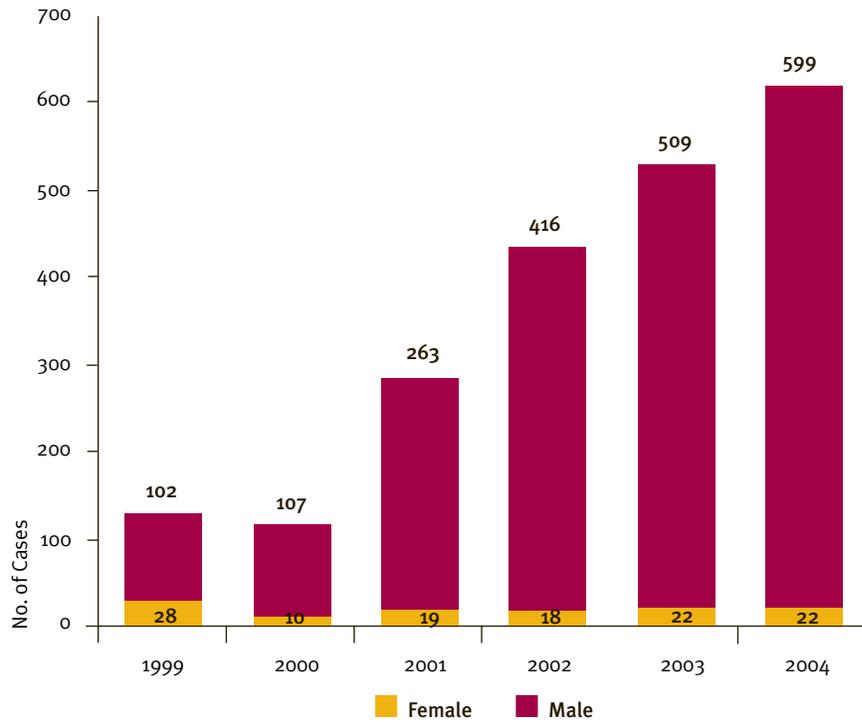
- Nadir at 1.1 cases per 100,000 population in 1998
- The overall NYC case rate in 2004 was 7.7 per 100,000 population
- 15.8/100,000 in men and 0.5/100,000 in women
- Over the past 4 years, case rates increased among men
- Congenital syphilis case rates remained low and relatively stable from 1999 through 2004

Fig. 5
P&S Syphilis Cases (Rate/100,000) by Sex, and Congenital Syphilis Cases (Per 1,000 Live Births), New York City, 2000 – 2004*



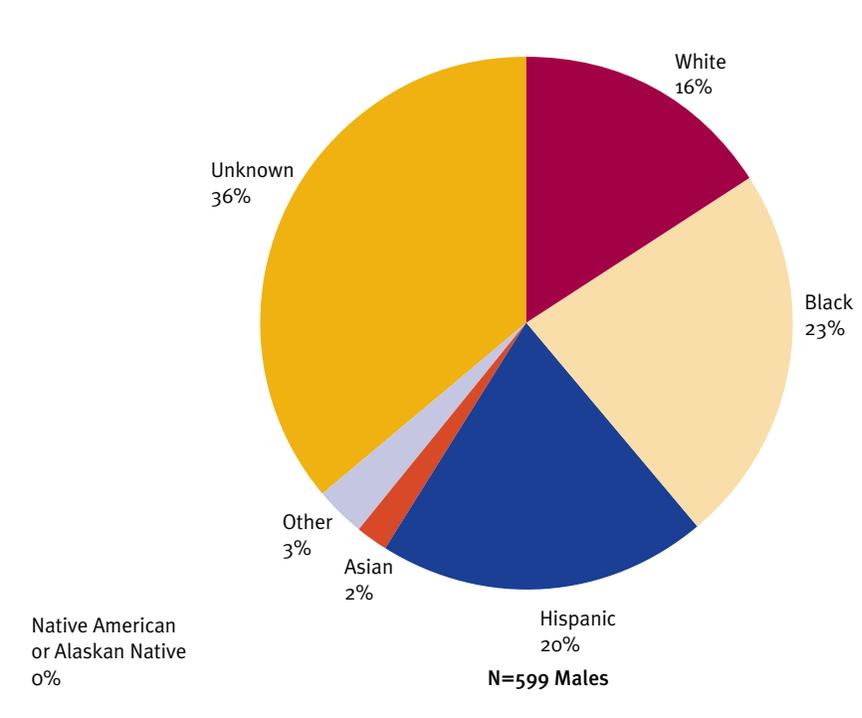
* For 2004 congenital rate, live birth denominator based on annualized 2003 live birth data provided by NYC DOHMH Vital Statistics

Fig. 6
P&S Syphilis Male-to-Female Case Ratio, New York City, 1999 – 2004



- Male-to-female case ratios increased considerably from 3.6:1 in 1999 to 27.2:1 in 2004
- In 2004, of 621 Syphilis cases citywide, 599 (96%) cases were among men
- 36 years was the median age of cases among men in 2004
- The current syphilis outbreak primarily affects men who have sex with men (MSM)

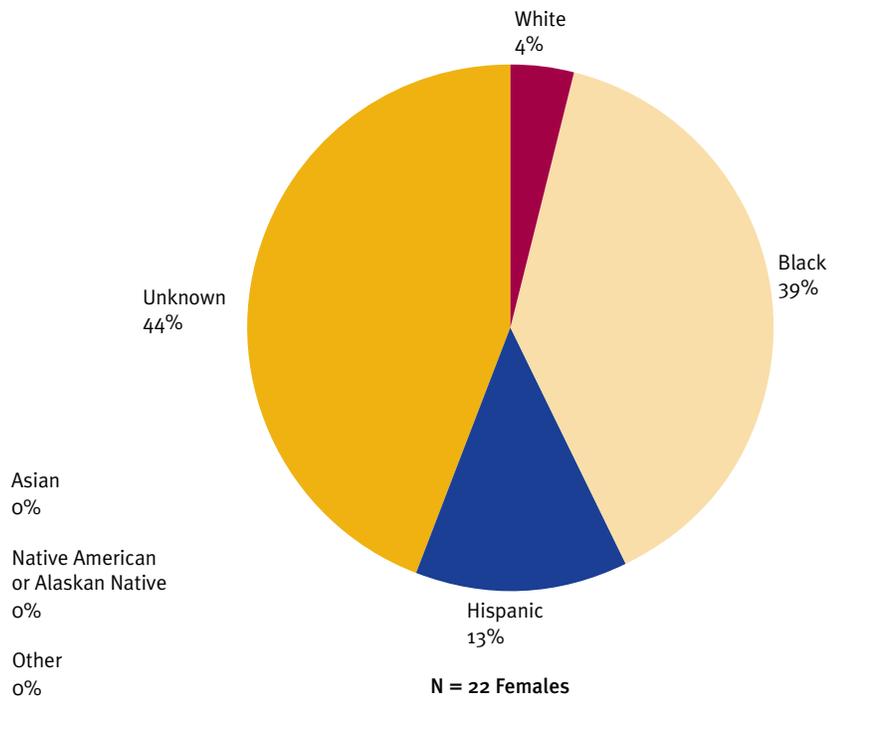
Fig. 7
P&S Syphilis Cases Among Men, by Race/Ethnicity, New York City, 2004



- Race/ethnicity is unknown for over 1/3 of cases in men
- In 2004, less than 1/5 of male P&S syphilis cases were among Non-Hispanic whites
- Almost 1/4 of cases were Non-Hispanic Black, and about 1/5 of reported cases were Hispanic

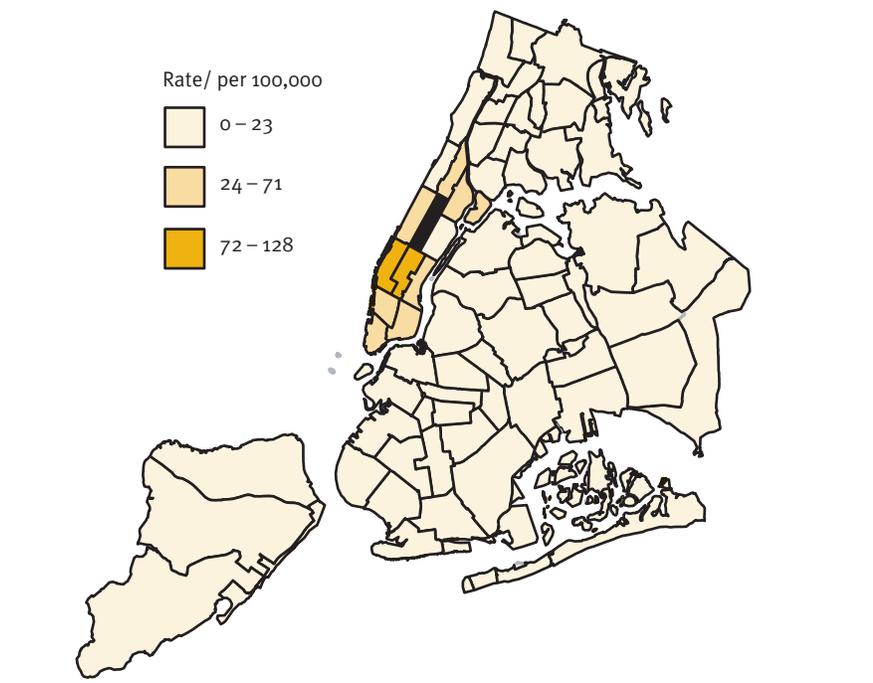
- Almost 1/2 of P&S syphilis cases among women had no reported ethnicity
- Black, non-Hispanic women accounted for more than 1/3 of cases overall
- Women of color (non-Hispanic black and Hispanic women) accounted for most cases for whom race/ethnicity was known

Fig. 8
P&S Syphilis Cases Among Women, by Race/Ethnicity, New York City, 2004



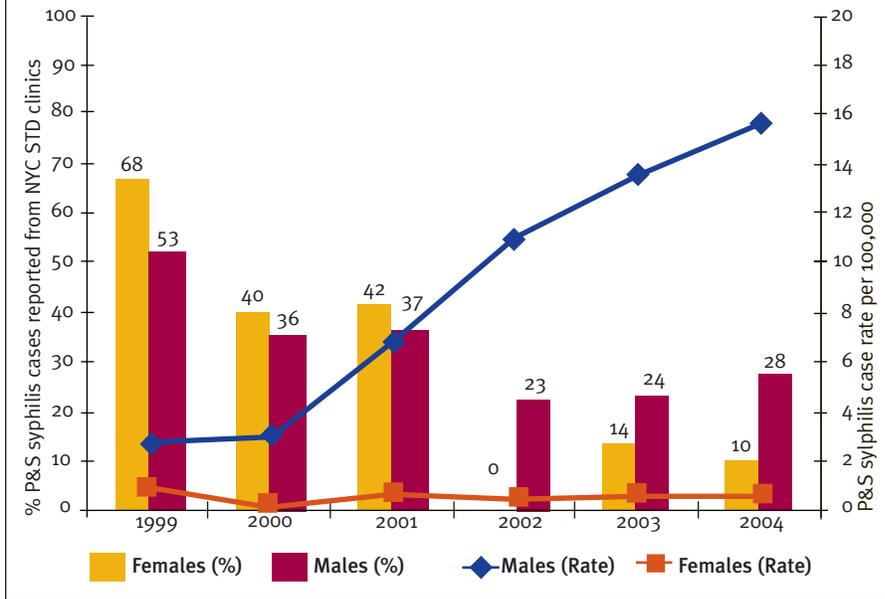
- Manhattan residents accounted for 54% of all new cases among men
- Manhattan neighborhoods accounted for top 5 UHF case rates:
 - Chelsea (128.4/100,000)
 - Central Harlem (70.6/100,000)
 - Gramercy Park (45.4/100,000)
 - Union Square (32.5/100,000)
 - Greenwich Village (30.5/100,000)

Fig. 9
P&S Syphilis Cases Among Men (Rate/100,000), by United Hospital Fund Neighborhood, New York City, 2004*



* For UHF Neighborhood names see Appendix B

Fig. 10
Sources of Syphilis Reporting: Public STD Clinics Compared to Hospitals and Private Physicians, by Sex and Case Rates, 1999 – 2004



- In 2004, hospitals and private providers diagnosed and reported most cases
- Public STD clinics have historically diagnosed most syphilis cases
- Ratios began to reverse in 1999
- DOHMH STD clinics currently account for less than 1/4 of all case reports

Gonorrhea

TABLE 3

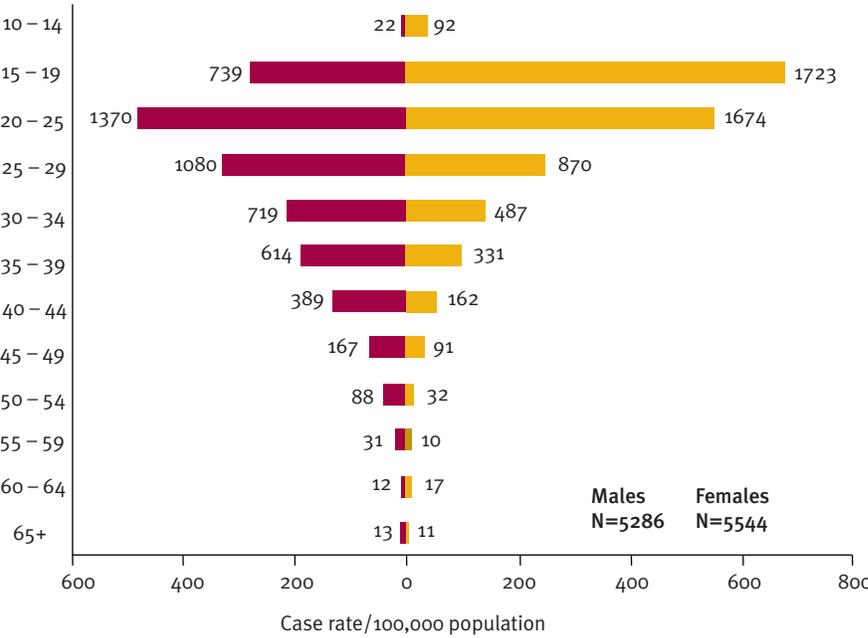
Gonorrhea Cases by Race/Ethnicity and Sex (Number and Rate/100,000 and Median Age), New York City, 2004*

Race/Ethnicity	N	Rate/100,000	Median Age** (years)
Asian/Pacific Islander			
Female	75	18.6	24
Male	50	12.5	26
Black			
Female	4165	372.2	21
Male	3915	433.8	26
Hispanic			
Female	1018	88.5	21
Male	756	70.4	26
Native American/Alaskan Native			
Female	20	220.1	18.5
Male	14	165.5	31
White			
Female	153	10.2	23
Male	475	34.4	33
Other Race/Ethnicity			
Female	129	418.7	24
Male	90	302.8	29
Total	10860	135.6	24

* Cases with unknown sex and race/ethnicity have been proportionally redistributed into the above categories

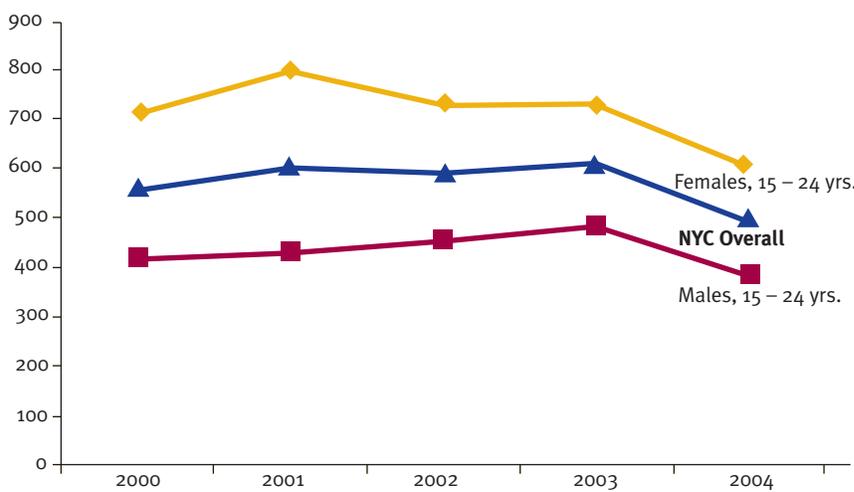
** Median age with unknown age excluded

Fig. 11
**Gonorrhea Cases, by Sex and Age (Number of Cases and Rate/100,000),
 New York City, 2004* Private Physicians, by Sex and Case Rates, 2004**



- The overall NYC case rate in 2004 was 135.6 per 100,000 population
- 139.3/100,000 in men and 131.6/100,000 in women
- In 2004, 10,860 cases of gonorrhea were reported
 - 5,286 in men
 - 5,544 in women
- Gonorrhea infection rates among men and women, ages 15 to 24 years, continued to be significantly higher than those of other age groups

Fig. 12
**Gonorrhea Cases, Overall and Among Persons Aged 15 – 24 Years,
 by Sex (Rate/100,000), New York City, 2000 – 2004***

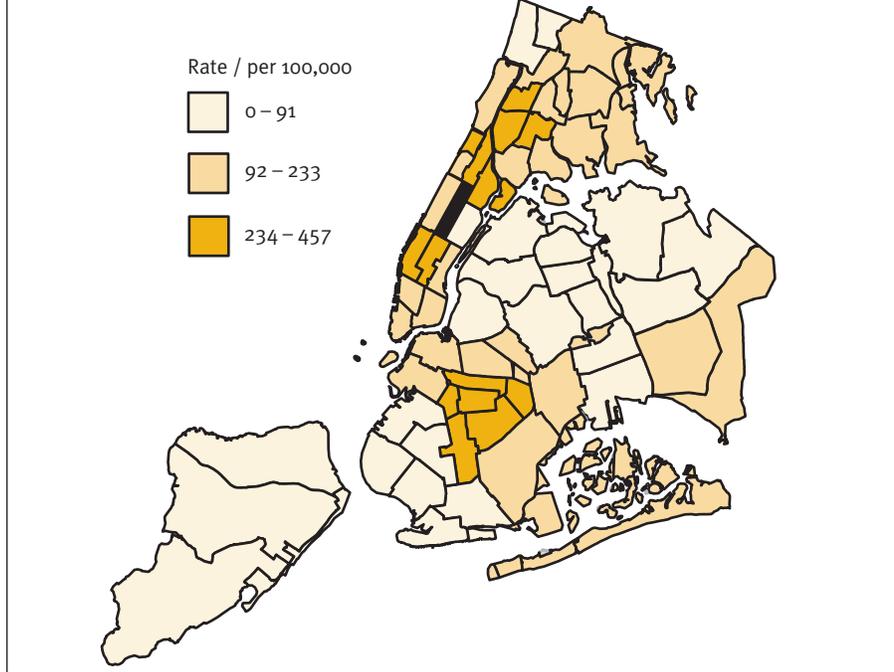


- Mirroring national trends, gonorrhea infection in young women aged 15 – 24 has slowly declined over the last 4 years

* Case rates calculated using cases for which sex and age are known

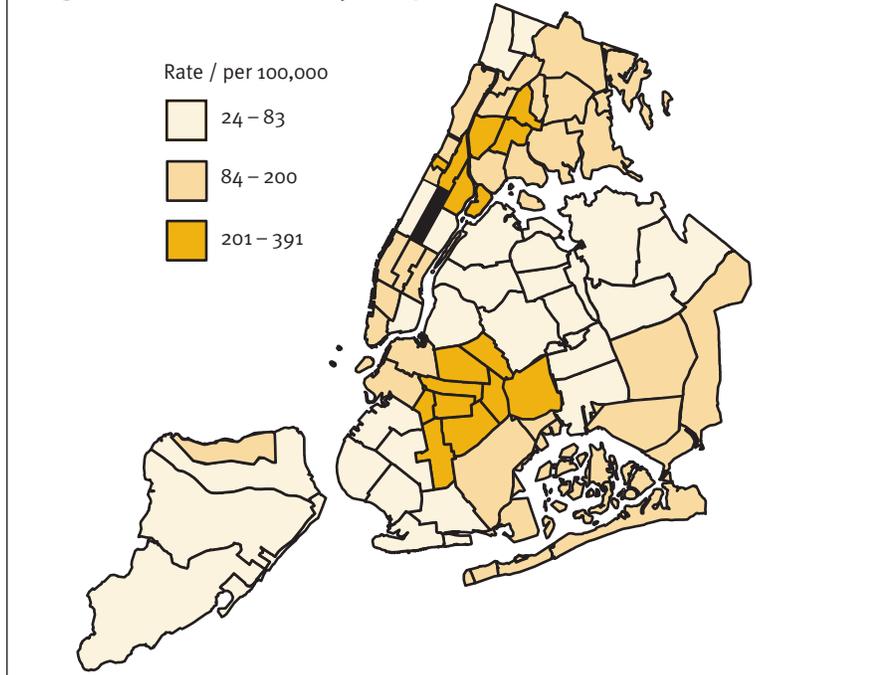
- Case rates among men were highest in Manhattan (281.0/100,000), exceeding the overall NYC rate among men (139.3/100,000)
- NYC neighborhoods with the highest case rates among men were:
 - Central Harlem (456.5/100,000)
 - Chelsea (429.0/100,000)
 - Crown Heights (402.9/100,000)

Fig. 13
Gonorrhea Cases Among Men (Rate/100,000), by United Hospital Fund Neighborhood, New York City, 2004*



- Rates among women in Brooklyn (180.3/100,000) and the Bronx (168.0/100,000) exceeded the overall NYC rate among women (131.6/100,000)
- 4 of the 5 five NYC neighborhoods with the highest rates among women were in Brooklyn:
 - Crown Heights (393.3/100,000)
 - East New York (346.4/100,000)
 - Williamsburg (272.7/100,000)
 - East Flatbush (260.5/100,000)
- In Manhattan, Central Harlem had the highest rate among women (262.0/100,000)

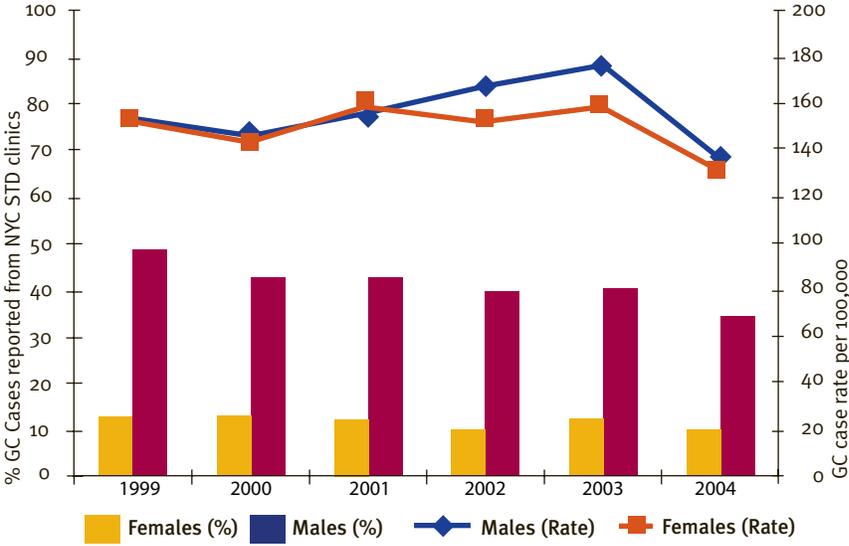
Fig. 14
Gonorrhea Cases Among Women (Rate/100,000), by United Hospital Fund Neighborhood, New York City, 2004*



* For UHF Neighborhood names see Appendix B

Fig. 15

Sources of Gonorrhea Reporting: Public STD Clinics Compared to Hospitals and Private Physicians, by Sex and Case Rates, 1999 – 2004



- In 2004, providers other than 10 NYC DOHMH STD clinics reported most cases
- Proportion of all cases in NYC originating from DOHMH STD Clinics, decreased slightly over the last 4 years

Chlamydia

TABLE 4

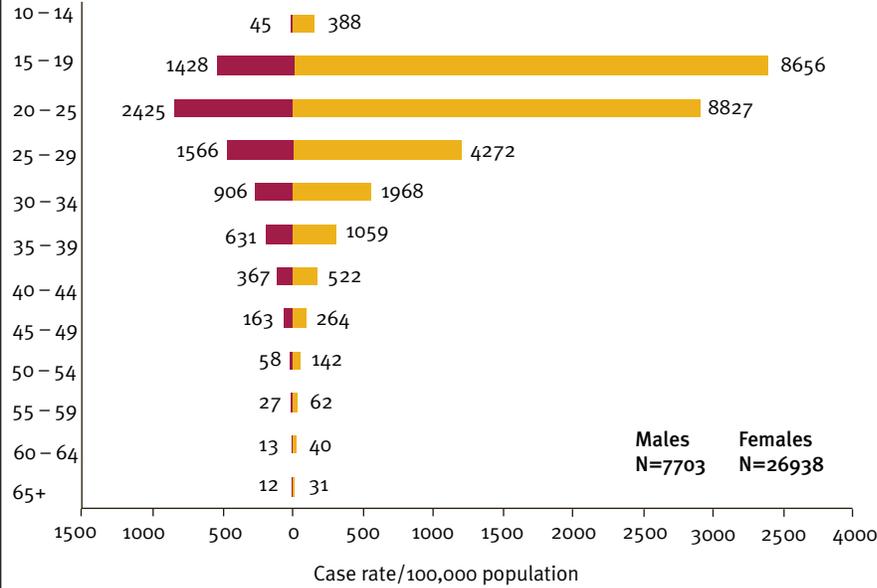
Chlamydia Cases, by Race/Ethnicity and Sex (Number of Cases and Rate/100,000 and Median Age),
New York City, 2004*

Race/Ethnicity	N	Rate/100,000	Median Age** (years)
Asian/Pacific Islander			
Female	960	238.3	27
Male	118	29.5	28
Black			
Female	16011	1430.7	21
Male	3915	433.8	26
Hispanic			
Female	7796	677.7	21
Male	1595	148.7	23
Native American/Alaskan Native			
Female	60	636.3	20
Male	33	393.1	28
White			
Female	897	59.8	23
Male	351	25.4	29
Other Race/Ethnicity			
Female	745	2419.5	23
Male	102	343.0	24
Total	34189	426.9	22

* Cases with unknown sex and race/ethnicity have been proportionally redistributed into the above categories

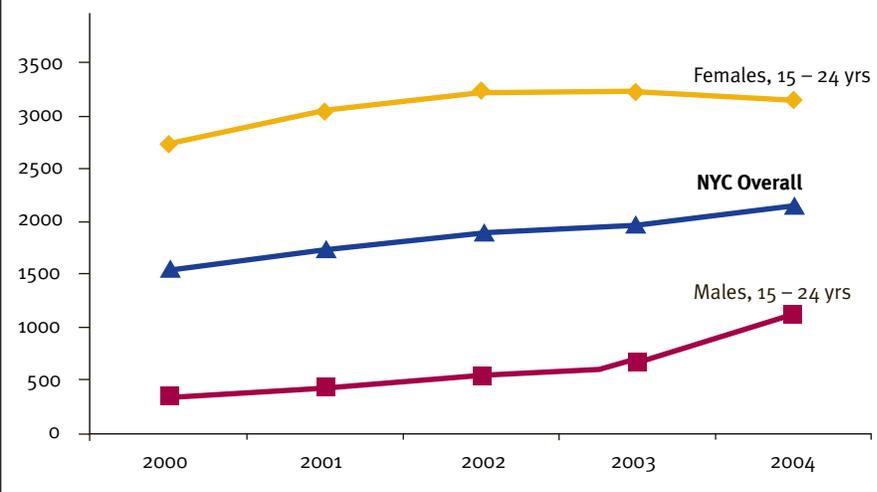
** Median age with unknown age excluded

Fig. 16
Chlamydia Cases, by Sex and Age (Number of Cases and Rate/100,000), New York City, 2004*



- The overall NYC case rate in 2004 was 426.9 per 100,000 population
- 203.0/100,000 in men and 626.4/100,000 in women
- In 2004, 34,641 cases were reported
- 7,703 in men
- 26,398 in women
- Chlamydia disproportionately affects adolescent women and young adults
- 65% of all cases reported in NYC in 2004 were among women, 15 – 24 years
- The rate among adolescent women continued to be notably higher than that of other age groups, as this age group is biologically more susceptible to infection and more likely to be screened for asymptomatic disease

Fig. 17
Chlamydia Cases, Overall and Among Persons Aged 15 – 24 Years, by Sex (Rate/100,000), New York City, 2000 – 2004*

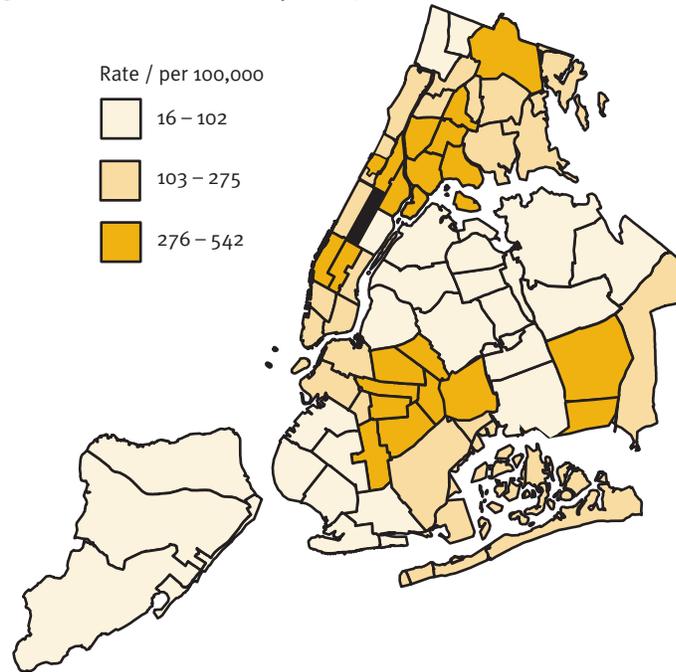


- Rates among women over the last 4 years remained steady and high compared to men in this age group
- Lower case rates among men, in general, reflect the fact that screening is still far less commonly performed for men than for women
- Increase in cases among men over the past 4 years is likely due to increased screening among men
- Case rate among men in 2004 increased substantially due to expanded screening of men in correctional facilities

* Case rates calculated for cases for whom sex and age are known

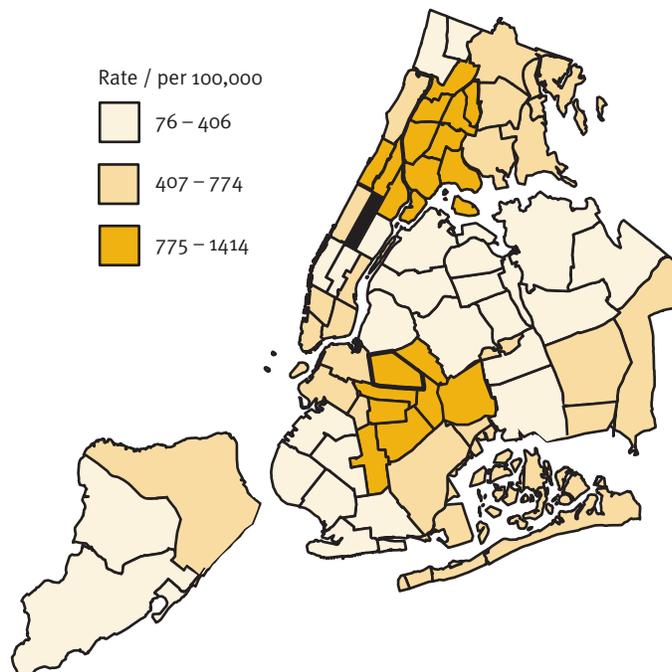
- Case rates among men were highest in Brooklyn and the Bronx (228.5/100,000 and 282.0/100,000), exceeding the overall NYC case rate among men (203.0/100,000)
- NYC neighborhoods with the highest case rates among men were:
 - Central Harlem (541.5/100,000)
 - Crown Heights (522.3/100,000)
 - East Flatbush (441.1/100,000)

Fig. 18
Chlamydia Cases Among Men (Rate/100,000), by United Hospital Fund Neighborhood, New York City, 2004*



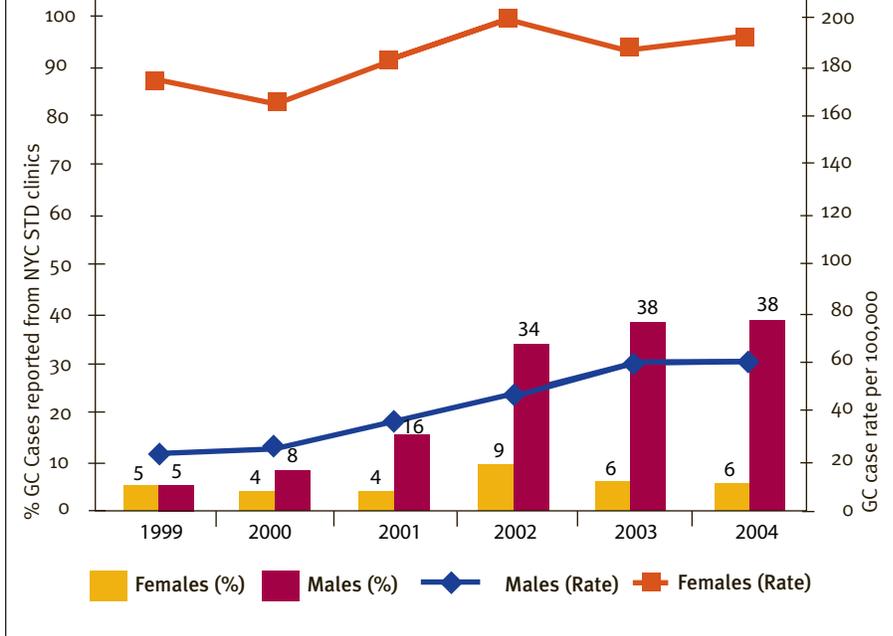
- The Bronx had the highest reported rates among women in New York City (906.9/100,000)
- Case rates among women were highest in 3 Brooklyn neighborhoods
 - Crown Heights (1,414.1/100,000)
 - East New York (1,354.7/100,000)
 - East Flatbush (1,253.9/100,000)

Fig. 19
Chlamydia Cases Among Women (Rate/100,000), by United Hospital Fund Neighborhood, New York City, 2004*



* For UHF Neighborhood names see Appendix B

Fig. 20
Sources of Chlamydia Reporting: Public STD Clinics Compared to Hospitals and Private Physicians, by Sex and Case Rates, 1999 – 2004



- Proportion of cases among men reported from DOHMH STD clinics increased over the past 5 years
- Reason for STD-based increases:
 - Introduction of highly sensitive Nuclear Amplification Assay Test in 1999
 - Introduction of universal testing for male patients in 2002 (universal testing of female patients was already in place)

Appendix A

Clinic Locations

Call 311 for hours of operation, locations, and services offered

Manhattan

- ▢ Central Harlem
2238 Fifth Avenue, 3rd Fl. (137th Street)
New York, NY 10037
- ▢ East Harlem
158 East 115th Street, 1st Fl. (off Lexington Avenue)
New York, NY 10029
- ▢ Chelsea
303 Ninth Avenue, 2nd Fl. (28th Street)
New York, NY 10001
- ▢ Riverside
160 West 100th Street (between Columbus/Amsterdam)
New York, NY 10025

Bronx

- ▢ Morrisania
1309 Fulton Avenue, 2nd Fl.
(E 169th Street off 3rd Ave)
Bronx, NY 10456

Staten Island

- ▢ Richmond
51 Stuyvesant Place, 1st Fl. (Wall Street)
St. George, NY 10301

Brooklyn

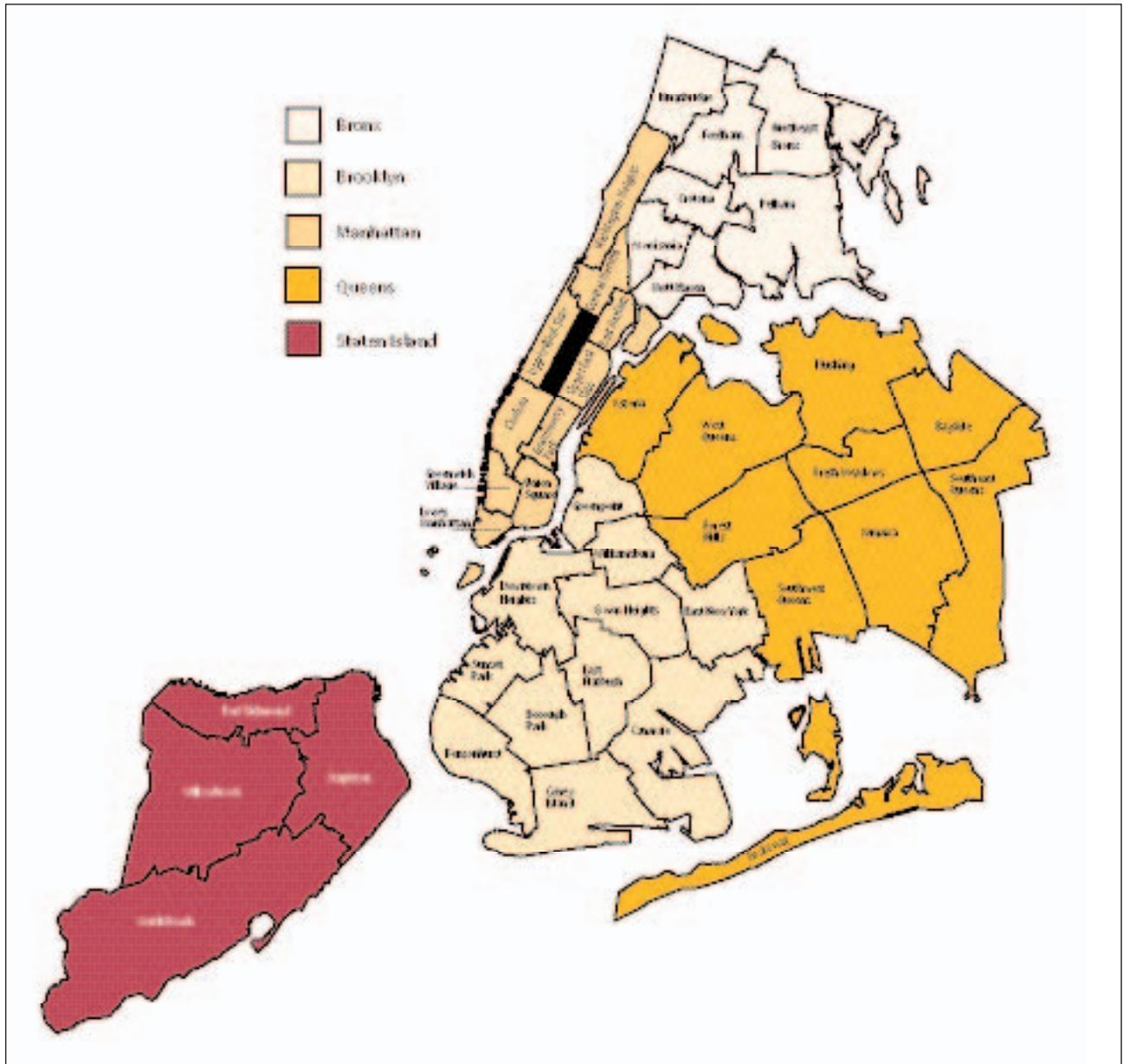
- ▢ Bushwick
335 Central Avenue
Brooklyn, NY 11221
- ▢ Fort Greene
295 Flatbush Ave. Ext. 2nd Fl.
Brooklyn, NY 11201

Queens

- ▢ Corona
34-33 Junction Blvd. (Roosevelt/Northern)
Jackson Heights, NY 11372
- ▢ Jamaica
90-37 Parsons Blvd. 1st Fl. (off Jamaica Ave.)
Jamaica, NY 11432

Appendix B

United Hospital Fund Neighborhoods



Our Mission

The Bureau of Sexually Transmitted Disease Control's primary mission is to prevent, control, and monitor sexually transmitted infections and their sequelae, and in the process, to promote sexual health among New Yorkers.

To achieve this mission, the Bureau:

- ▣ Provides direct clinical services and partner services;*
- ▣ Monitors existing and emerging disease trends;*
- ▣ Conducts research about risk behaviors, treatment, and prevention;*
- ▣ Collaborates with community groups, private providers, and other agencies;*
- ▣ Performs outreach, including educational programs.*

Our Core Activities

Prevention

- ▣ Promoting sexual health behaviors that prevent Sexually Transmitted Diseases (STDs), including abstinence, limiting the number of sex partners, condom use and vaccinations as appropriate.
- ▣ Disseminating information to individuals at risk through media campaigns and partnerships with community-based organizations and other agencies.

Control

- ▣ Controlling the spread of STDs and removing barriers to care by offering a range of educational and clinical programs for health care providers and the public;

diagnostic, counseling, partner notification, and referral services for individuals exposed to HIV and other STDs; emergency contraception; vaccinations for hepatitis A and B; and screening for hepatitis C.

Surveillance

- ▣ Using mandated provider and laboratory reports, sentinel site and behavioral surveillance, and data from epidemiologic investigations to monitor trends in disease and disease determinants.
- ▣ Continuously improving the integrity and accuracy of data to gain a clearer understanding of disease trends, prevalent sexual attitudes and behaviors.

Notes



nyc.gov/health

THE NEW YORK CITY DEPARTMENT
of HEALTH and MENTAL HYGIENE
Michael R. Bloomberg, Mayor
Thomas R. Frieden, M.D., M.P.H., Commissioner

