

## Bureau of Sexually Transmitted Disease Control

Annual Report 2005



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

# Letter from the Commissioner

*Sexually transmitted diseases (STDs) affect more than 60,000 New Yorkers each year. All are preventable, and many can be treated. We have made progress in improving the sexual health of New Yorkers, but there are areas where we can and should do 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, it is increasing among men. Chlamydia rates remain high but steady among women and are increasing among men—due at least in part to more screening of correctional populations. For the first time since 1999, the number of syphilis cases in New York City fell.*

*All New Yorkers should know how to prevent STDs, and that free, confidential testing, treatment and condoms are available at Health Department STD clinics. Anyone 12 years of age and older can receive services free of charge, without the knowledge or consent of a parent or spouse. No one will ask any questions about immigration status. If needed, we can confidentially notify partners without disclosing the identity of the person who may have exposed them to HIV or other STDs.*

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

*Sincerely,*



*Thomas R. Frieden, MD, MPH  
Commissioner*

# 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 condom use; limiting the number of sex partners; vaccination, as appropriate; and abstinence.
- 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, as well as data from epidemiologic investigations to monitor trends in disease, and disease determinants.
- Continuously improving the completeness and accuracy of data to gain a clearer understanding of trends in disease and sexual behavior.

## Contents

Executive Summary .....	5
2005 Program Activities .....	8
Organizational Chart .....	9
Prevention & Control .....	9
Surveillance .....	12
Epidemiology & Research .....	13
Profile of Selected Sexually Transmitted Diseases .....	14
Syphilis .....	16
Gonorrhea .....	21
Chlamydia .....	25
How to Report a Sexually Transmitted Disease .....	32

## Tables

1 P&S Syphilis, Gonorrhea, and Chlamydia Cases and Case Rate per 100,000 Persons, by Sex, Age, Race/Ethnicity, and UHF Neighborhoods, NYC, 2005 .....	14	10 Proportion of NYC P&S Syphilis Cases Diagnosed and Reported by Public STD Clinics, by Sex, with Citywide Case Rates per 100,000 Persons, 2000–2005 .....	20
2 P&S Syphilis Cases and Case Rate per 100,000 Persons, by Race/Ethnicity and Sex, with Median Age, NYC, 2005 .....	16	11 Gonorrhea Cases and Case Rates per 100,000 Persons, by Sex and Age NYC, 2005 .....	22
3 Gonorrhea Cases and Case Rate per 100,000 Persons, by Race/Ethnicity and Sex, with Median Age, NYC, 2005 .....	21	12 Gonorrhea Case Rate per 100,000 Persons, All Ages and Among Persons Aged 15–24 Years, by Sex, NYC, 2000–2005 .....	22
4 Chlamydia Cases and Case Rate per 100,000 Persons, by Race/Ethnicity and Sex, with Median Age, NYC, 2005 .....	25	13 Male Gonorrhea Case Rates per 100,000 Persons, by UHF Neighborhood, NYC, 2005 .....	23
		14 Female Gonorrhea Case Rates per 100,000 Persons, by UHF Neighborhood, NYC, 2005 .....	23
		15 Proportion of NYC Gonorrhea Cases Diagnosed and Reported by Public STD Clinics, by Sex, with Citywide Case Rates per 100,000 Persons, NYC, 2000–2005 .....	24
		16 Chlamydia Cases and Case Rates, per 100,000 Persons, by Sex and Age, NYC, 2005 .....	26
		17 Chlamydia Case Rate per 100,000 Persons, All Ages and Among Persons Aged 15–24 Years, by Sex, NYC, 2000–2005 .....	26
		18 Male Chlamydia Case Rates per 100,000 Persons, by UHF Neighborhood, NYC, 2005 .....	27
		19 Female Chlamydia Case Rates per 100,000 Persons, by UHF Neighborhood, NYC, 2005 .....	27
		20 Proportion of NYC Chlamydia Cases Diagnosed and Reported by Public STD Clinics, by Sex, with Citywide Case Rates per 100,000 Persons, NYC, 2000–2005 .....	28

## Figures

1 P&S Syphilis Cases, by Year and Sex, NYC, 2000–2005 .....	7
2 Gonorrhea Cases, by Year and Sex, NYC, 2000–2005 .....	7
3 Chlamydia Cases, by Year and Sex, NYC, 2000–2005 .....	7
4 P&S Syphilis Cases and Case Rate per 100,000 Persons, NYC, 1940–2005 .....	17
5 P&S Syphilis Cases & Case Rate per 100,000 Persons, by Sex, & Congenital Syphilis Cases & Case Rate per 1,000 Live Births, NYC, 2000–2005 .....	17
6 P&S Syphilis, Male-to-Female Case Ratio, NYC, 2000–2005 .....	18
7 Male P&S Syphilis Cases, by Race/Ethnicity, NYC, 2005 .....	18
8 Female P&S Syphilis Cases, by Race/Ethnicity, NYC, 2005 .....	19
9 Male P&S Syphilis Case Rates per 100,000 Persons, by UHF Neighborhood, NYC, 2005 .....	19

## Appendices

A Clinic Locations .....	29
B UHF Map .....	30
C UHF Zip Code Table .....	31

# Executive Summary

*In 2005, the Bureau of Sexually Transmitted Disease Control continued to make significant progress in improving the sexual health of New Yorkers. It is an ongoing challenge, requiring close cooperation and collaboration among the Bureau's public health professionals, the medical community, the individuals we serve, and the community-based organizations that represent them.*

*Our approach is multi-faceted. In addition to providing direct clinical and partner services throughout the City's 5 boroughs, we are committed to building awareness of both risk factors and safer sex practices. We do this through shared data, regular communication, and a range of educational initiatives. Improvements in data gathering also help us to respond more quickly and more accurately to emerging diseases and disease trends, and to populations at increased risk for disease.*

*The 2005 report sets forth key aspects of the Bureau of STD Control program, particularly as it focuses on the 3 major STDs—syphilis, gonorrhea, and chlamydia. This Executive Summary presents an overview of the state of STDs in New York City, and covers some of our most significant accomplishments for the year. It includes 6-year figures or trends for the 3 key bacterial reportable STDs, to illustrate the shifting nature of the challenges we face. The report also provides information—including tables and figures—that describes our activities for the year.*

## Key Accomplishments

The Bureau achieved many of its objectives in 2005, introducing a number of new programs as well as community-based and epidemiologic initiatives. Our most significant accomplishments follow, and are described in greater detail later in this report:

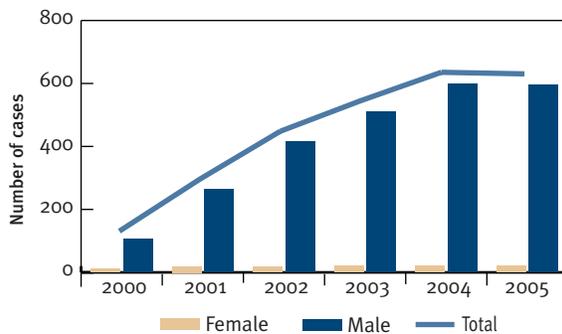
- The Bureau completed its Electronic Medical Record (EMR) project during August 2005. All 10 of the Bureau's clinic sites now have a fully automated patient medical record.
- In early 2005, the Bureau switched to Rapid Oral HIV-1/2 testing. The number of patients tested for the year increased by 24% from 38,000 in 2004 to 47,000 in 2005.
- In 2005, 2 clinics, Jamaica, in Queens, and Fort Greene, in Brooklyn, completed renovations and were opened to rave reviews.
- In 2005, we expanded our "Hot Shot!" project to sites in the Bronx, Brooklyn, and Queens. Two grant awards were given to community-based organizations to conduct syphilis and other health screening services throughout the year.
- To address the increased importance of STDs and HIV among women, a new project, Women's Health on the Agenda (WHOA), was implemented in 2005.
- In May of 2005, the Bureau reorganized. The goal was to consolidate partner service functions by creating a new Case Investigations and Partner Services Unit. This unit conducts case interviews and partner notification for all early syphilis, and lymphogranuloma venereum diagnosed in New York City (NYC); for fluoroquinolone-resistant gonorrhea; and for HIV cases diagnosed in BSTDC clinics.
- During 2005, the Office of Correctional Public Health successfully implemented a male chlamydia and gonorrhea screening program at Rikers Island Adult Correctional Facility.
- During 2005, the Bureau led an investigation into cases of neonatal herpes, which were found to be epidemiologically linked to a religious circumcision practice.

## Trends

STDs do not affect all cities, communities, or neighborhoods equally. Case rates of syphilis, gonorrhea, and chlamydia in NYC are higher than those in approximately half of large (>200,000 population) cities in the United States. P&S syphilis cases are primarily concentrated among the MSM (men who have sex with men) population. Gonorrhea and chlamydia disproportionately affect adolescents, women, and African American and Hispanic populations.

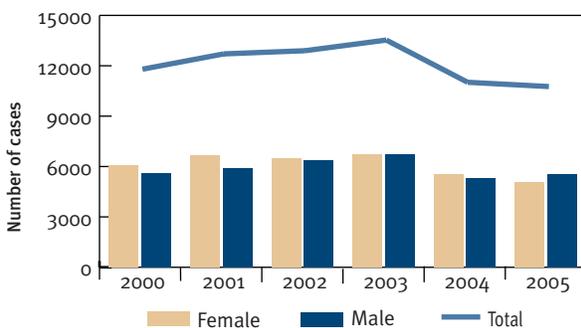
The number of P&S syphilis cases decreased among men in NYC in 2005; the number of cases among women has remained small and constant since 2003 (Fig.1).

**Fig. 1**  
**P&S Syphilis Cases, by Year and Sex, NYC, 2000–2005**



The number of reported cases of gonorrhea fell from 10,860 in 2004 to 10,596 in 2005. Despite an overall

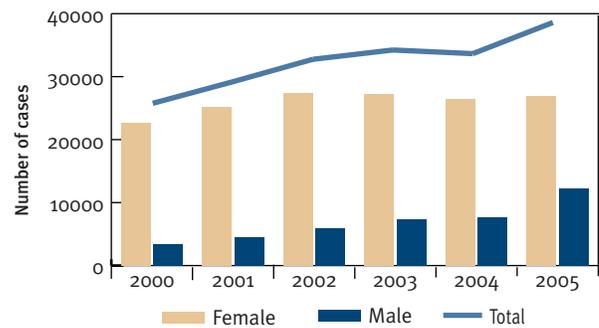
**Fig. 2**  
**Gonorrhea Cases, by Year and Sex, NYC, 2000–2005**



drop in gonorrhea cases over the last decade, year-end figures show that the number of cases diagnosed among men is increasing (Fig.2).

Case rates for chlamydia, the most commonly reported bacterial infection, continued to rise among New Yorkers in 2005, most notably among men. It is likely that the observed increase in the number of cases of chlamydia diagnosed and reported among men is due to providers conducting more testing among the male population, including males admitted to NYC correctional facilities (Fig.3).

**Fig. 3**  
**Chlamydia Cases, by Year and Sex, NYC, 2000–2005**



Our progress in 2005 has been substantial. We have fully implemented our Electronic Medical Record system in all 10 STD clinics, and we are also exploring options to use the Internet to do some HIV partner notification. In 2006, we will begin to implement a chlamydia/gonorrhea education, screening, and treatment program in high schools in high morbidity Bronx and Brooklyn neighborhoods.

In conclusion, I would like to acknowledge and thank our dedicated Bureau of STD Control staff. Their unwavering support allows us to sustain our multi-faceted program in the field, at our clinics, and in the Central Office. Their continuing dedication will enable us to expand and improve our efforts to prevent and control STDs in New York City, and to help improve the health of all New Yorkers.



Susan Blank, M.D., M.P.H.

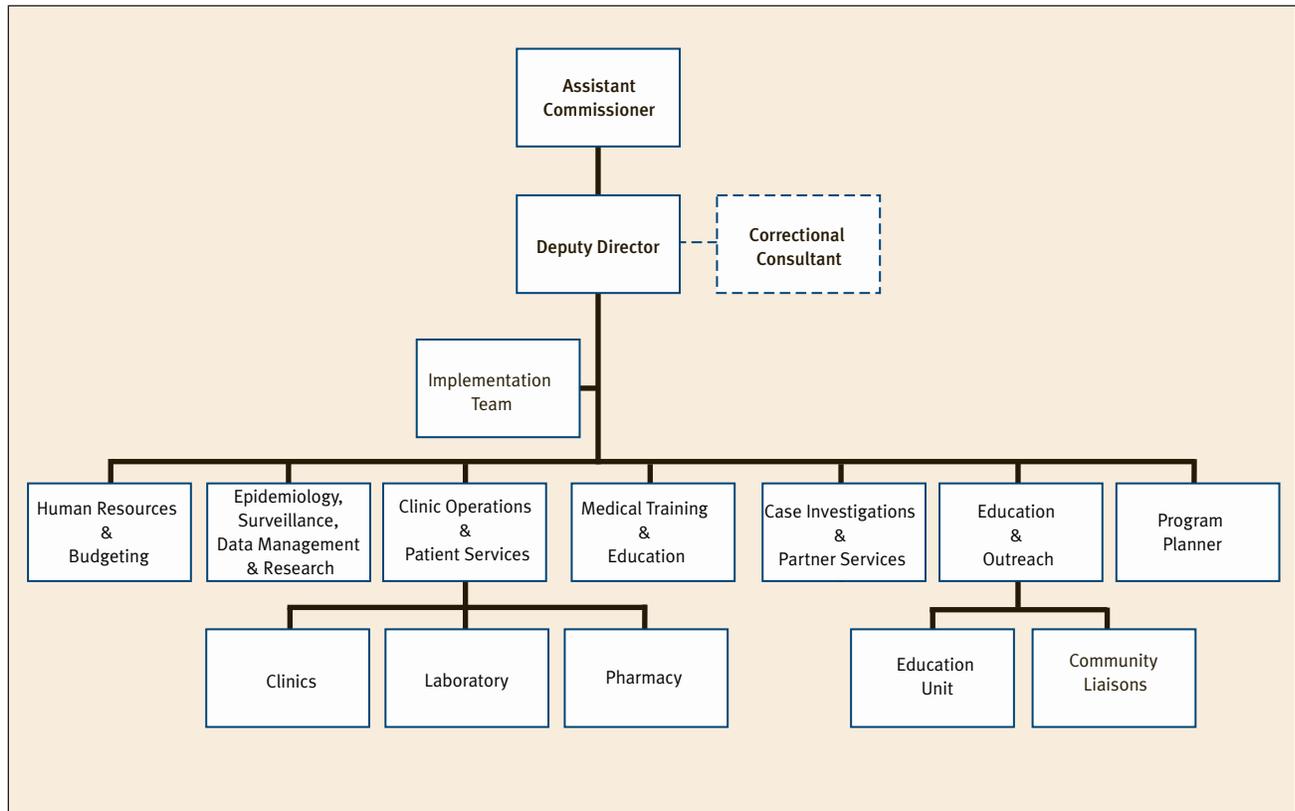
Assistant Commissioner, Bureau of STD Control

# 2005 Program Activities

## The Bureau of STD Control - Units and Their Functions:

- **Correctional Consultant** serves as a liaison between the Bureau and Correctional Health Services at Riker's Island Adult Correctional Facilities.
- **Implementation Team** advances new initiatives, as well as develops, plans, executes, and evaluates projects in conjunction with other Bureau units.
- **Human Resources & Budgeting** handles personnel and budget issues, serves as liaison to the Bureau's personnel and fiscal responsibilities, and manages requests for funding and use of funds.
- **Epidemiology & Surveillance** ensures that cases are reported; receives laboratory and provider reports; monitors disease and behavioral trends; and devises research initiatives and special methods for in-depth case investigation, in the context of emerging diseases and outbreaks.
- **Medical Training & Education** coordinates Continuing Medical Education (CME) credit courses for NYC Providers, and houses the CDC-funded Region II STD/HIV Prevention Training Center.
- **Clinic Operations & Patient Services** encompasses all patient services at our 10 clinics, including medical, laboratory, pharmacy, patient education, ancillary services, and clinic administration.
- **Case Investigation & Partner Services** investigates all cases of early syphilis and lymphogranuloma venereum throughout New York City, as well as cases of HIV and fluoroquinolone-resistant gonorrhea diagnosed in our STD clinics. The unit notifies partners identified through 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 the public, community-based organizations, and other important agencies.
- **Program Planner** coordinates programmatic and physical improvements for the Bureau, handles clinic and staff complaints, coordinates staff training, and serves as the liaison to the Equal Employment Opportunity Office.

## Bureau of STD Control Organizational Chart



### Prevention & 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. We consider the promotion of healthy sexual decision-making and behaviors, which prevent the acquisition and spread of STDs, to be among our most important tasks.

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

### Significant Initiatives

#### Outreach Activities in 2005

The Bureau’s Education Unit conducted more than 1,300 presentations in New York City schools to raise awareness about HIV and other STDs. Our community-based organization (CBO) staff conducted more than 250 technical assistance and training workshops for 6 Community Boards, and for the New York City Board of Education School Safety Division. The Unit represented the Bureau of STD Control at more than 150 Health Fairs throughout the 5 boroughs, reaching some 32,000 people.

In 2005 “Hot Shot!” was expanded to the Bronx, Brooklyn and Queens. To do this, we awarded CDC-based funding to 2 CBOs. The goal: to perform syphilis testing, through a holistic health framework, among MSM of color in all 5 boroughs. Services available at the events included STD and HIV testing, hepatitis A and B vaccinations, smoking cessation patches, and (when available) blood pressure/glucose monitoring and mental health screening. The 2 organizations reached out to more than 4,550 individuals at 24 different events.

The Bureau partnered with People of Color in Crisis, and with the Young Men who have Sex with Men (YMSM) Coalition, to bring STD screening and hepatitis A and B vaccination to YMSM of color at the annual “Taking Our eXperiences Into the Community (TOXIC)” youth conference. This event was attended by 250 gay, bisexual, lesbian and transgender African-American and Latino youth.

Realizing that the Internet is an important vehicle to promote STD/HIV prevention and control awareness, the Bureau awarded funding for a community-based organization to develop Internet outreach. The CBO designed a web-based survey of sexual practices, addressing MSM seeking relationships or sex partners through the Internet. Participants were recruited through the chat rooms and were invited to complete the survey during 2005. Data will be included in the 2006 Annual Report.

Women are more likely to be asymptomatic for STDs and because of this they tend to suffer a disproportionate share of adverse outcomes. To address this, the Bureau launched a new project called Women’s Health on the Agenda (WHOA!). The purpose is to promote physical and mental health and wellness, and particularly to promote STD/HIV screening for sexually active women of all ages, through collaboration with the faith-based community.

In collaboration with the Bureau of Maternal, Infant and Reproductive Health, the Bureau of HIV/AIDS Prevention and Control, and the Division of Mental Hygiene, we organized a successful event at York College, celebrating National Women’s Health Week in May 2005. Of the 225 people who attended the forum and health fair, 180 completed health surveys. Data analysis will be completed for inclusion in the 2006 Annual Report.

### Patient Care Citywide in 2005

The Bureau and the Region II STD/HIV Prevention Training Center (PTC) provided clinical training in STD/HIV prevention and care throughout 2005. A total of 179 clinical providers attended a 3-day STD intensive course, which included didactic and clinical training. In addition, 86 providers attended a syphilis update co-sponsored by the NY/NJ AIDS Education Training

Center. More than 17 grand rounds presentations were provided at major medical centers and professional venues throughout the city. At all trainings, attendees received both a full copy and a laminated summary card of the 2002 CDC STD Treatment Guidelines; a listing of NYC DOHMH STD clinics; information on partner notification; STD/HIV reporting forms; information on the syphilis outbreak in New York City; NYC DOHMH Health Alerts on quinolone-resistant neisseria gonorrhoea (QRNG); lymphogranuloma venereum (LGV); HIV; and information on additional PTC-sponsored CME/CNE activities. Grand Rounds topics included syphilis, LGV, STD Overview, Genital Ulcer Disease Overview, STDs in Adolescents, the Changing Epidemiology of STDs in NYC and Their Relevance for Clinical Practice, STDs in Men, and other additional topics.

As part of our adolescent-focused initiatives, the Prevention and Training Center (PTC) offered five 3-day STD adolescent intensive courses for clinical providers. Two STD intensive courses were offered in New York City; one course was offered in Puerto Rico; and two courses were offered in Rochester, New York.

In 2005, the Bureau also systematically surveyed 2,000 New York City physicians, nurse practitioners, and physician assistants who evaluate patients with STDs. It assessed knowledge, attitudes, practices and needs concerning STD screening, diagnosis, treatment, reporting, and partner notification. The majority of providers were aware of the legal reporting requirements for syphilis (90%), AIDS (81%), HIV (79%), and gonorrhoea (73%), and chlamydia (63%). When asked specifically about reporting behaviors, 53% of providers reported that they regularly report names to the health department for lab confirmed cases of gonorrhoea and chlamydia. Over 40% of providers reported limited or fair proficiency in the following areas: discussing adolescent sexual activity; discussing sexual health with lesbian, gay, bisexual and transgender patients; discussing emergency contraception; asking patients to provide names of sex partners; and describing DOHMH partner notification services. The information gathered in this survey was used to update the provider training curriculum available through the Region II STD/HIV PTC.

### STD Clinics

In 2005 we completed the design, programming, installation, and training for a paperless Electronic Medical Record (EMR) system. The system was implemented in all 10 of our clinics by year's end.

Point-of-care screening for HIV both eliminates the barrier posed by turnaround time for standard HIV testing and speeds referral for HIV primary care. In 2005, the Bureau began using the OraQuick® Advance Rapid HIV-1/2 Antibody Test, which provides results in as little as 20 minutes. We also instituted a quality control step into our oral rapid HIV testing, to maximize the number of true preliminary positives. Testing volume in BSTDC clinics increased by nearly 24% in 2005, to approximately 47,000 HIV tests.

The Bureau participated in a multi-site CDC-sponsored study to evaluate the effectiveness of condom use messages. The study, called VOICES/VOCES, is based at the Central Harlem STD clinic. Data collection are complete. Our partner, the Educational Development Company, will provide data analysis results, which will be presented in the 2006 Annual Report.

As part of a Department commitment to increasing New Yorkers' access to condoms and other prevention tools, we changed our practice of condom distribution in STD clinics in 2005. Previously, patients had been provided 3 condoms per person per visit. Now they can take as many as they like from a variety of locations in each of our clinics.

### Improved Facilities

Our Jamaica STD clinic has been renovated. It reopened in the spring of 2005.

Renovations, which both enhanced and increased clinic size, were completed at Fort Greene STD clinic in September of 2005.

### Partner Services

In mid-2005, the Bureau consolidated partner service functions and created a Case Investigations and Partner Services Unit. This unit conducts case

interviews and partner notification activities for all early syphilis, lymphogranuloma venereum, and BSTDC clinic-based fluoroquinolone-resistant gonorrhea and HIV-positive cases.

The goal of partner notification is to alert sex and needle-sharing partners of persons diagnosed with STDs and HIV about their potential exposure, their need for testing, and for possible treatment. Services include: providing information regarding current infections of concern; confidentially identifying, notifying, and ensuring appropriate medical attention for partners and other high-risk individuals; providing client-centered counseling to reduce the likelihood of future STD infection; providing referrals to additional medical or social services; as well as defining and better targeting the at-risk population, while assuring complete confidentiality for the client.

The Contact Notification Assistance Program (CNAP) is available to HIV-positive individuals at any stage of infection. It is also available to providers concerned about notifying at-risk partners of HIV-infected patients. All CNAP services are free. Health insurance, proof of citizenship, and parental consent are NOT required. Callers who wish to remain anonymous may do so. Those seeking help in notifying a partner may identify themselves with a number or code name of their choice, which they have also shared with their provider. Providers are contacted to verify that the individuals (identified only through the code name) are truly HIV infected, thus preventing the use of CNAP for malicious intent.

The CNAP program also offers technical assistance to community-based medical and social service providers and provides workshops for HIV service providers. CNAP works with medical providers to ensure that they understand the New York State HIV Reporting and Partner Notification Law. While the law mandates the reporting of HIV, partner notification remains voluntary. Providers are expected to include the names of all known sex and/or needle-sharing partners, and the status of partner notification for each identified partner. As part of that report, providers can request assistance in notifying known partners.

## Surveillance

The Surveillance and Epidemiology staff ensure thorough and accurate reporting of STD cases, maintain and improve the completeness and accuracy of gathered data, and interpret and disseminate those data in a timely fashion.

Since most STDs are asymptomatic, and several of the most common ones routinely go unreported, national surveillance systems seriously underestimate the actual numbers. It is estimated that more than 65 million people in the United States have an STD at any given 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 billion.<sup>1</sup> Two-thirds of these new cases—which are largely preventable—occur in people aged 24 and younger. Infertility, increased risk for acquiring HIV, and adverse pregnancy outcomes are among the potential, severe, lifelong consequences.

## Significant Initiatives

### Electronic Medical Record

During 2005, a Data Manager was hired to help implement the Electronic Medical Record (EMR), and to manage data accruing in the system. At that time, staff developed policies and procedures for the use of EMR and created and posted a data dictionary, including a “map” of key links among numerous EMR data tables. Regular reports using EMR data have replaced hand-tabulated reports, and are providing insight into a multitude of clinic utilization and quality assurance issues, such as staff productivity and adherence to recommended policies and procedures aimed at optimizing patient care.

### Electronic Record Keeping

An increasing number of laboratories reporting STDs have been certified to do so via the Electronic Clinical Laboratory Reporting System (ECLRS). By year-end 2005, more than 60% of all chlamydia and gonorrhea cases reported in New York City were imported directly into the Surveillance Registry. This eliminates the need for Bureau staff to complete and send paper reports to Central Office staff for data entry.

### Biennial Laboratory Survey

The Bureau conducted its Biennial Laboratory Survey during 2005. The survey provides valuable information on the volume and types of STD testing performed by laboratories certified to test New York City residents. In 2005, data were available for 172 responding laboratories. The data show a notable increase in the proportion of laboratories reporting to the Health Department electronically. Survey data presented at local meetings are routinely shared with other partners and with the public.

### CDC Sentinel Surveillance Grant

The Bureau received a 3-year grant to participate, as 1 of 6 sites, in a CDC-funded project entitled the Sentinel Surveillance Network (SSuN). This network of geographically diverse STD programs has the capability to submit electronic data, which includes more detail than routine surveillance data, in a timely and flexible fashion. SSuN provides monthly data on patient demographic, behavioral and clinical characteristics, which provides a more current and in-depth picture of disease trends and emerging STD issues. The grant supports a City Research Scientist, who serves as the surveillance coordinator/data manager for the SSuN project.

### Chlamydia and Gonorrhea Screening Implemented at Rikers Male Facilities

The Office of Correctional Public Health, Division of Health Care Access and Improvement, within the NYC DOHMH, successfully implemented a chlamydia and gonorrhea screening program at the Rikers Island Adult Correctional Facilities for men aged 35 years and younger. This program led to a dramatic increase in the proportion of male chlamydia cases reported from correctional facilities, from 5% in 2004 to 35% in 2005 among all male citywide cases.

### Established Enhanced Surveillance System for Lymphogranuloma Venereum

In February 2005, after laboratory confirmation of 2 cases of lymphogranuloma venereum—an invasive strain of chlamydia—the Bureau issued a Health Alert to area physicians. The alert covered both the signs and symptoms of infection and the probable at-risk population. The Bureau issued a second alert in April,

<sup>1</sup> <http://www.cdc.gov/std/stats/trends2004.htm>

focusing on clinical signs and symptoms in women. New York City providers wishing to test patients for LGV received detailed instructions for specimen collection and transport, and the Bureau played a central role in facilitating testing, arranging for specimen transport, and testing. Initially, the US Centers for Disease Control and Prevention (CDC) assisted with testing. Subsequently, the New York State Public Health Laboratory (Wadsworth Labs) developed a nucleic acid amplification test to support efforts to diagnosis LGV. In 2005, the Bureau aided providers in conducting partner elicitation and notification for confirmed LGV cases.

## Epidemiology & Research

### Quarterly Report of STD Surveillance Data Automated

Production of the Bureau's quarterly Surveillance and Epidemiology report, initially created in late 2003, has now been automated, permitting rapid production. The report is posted on the NYC DOHMH Internet site, enabling the public to have routine access to aggregate STD data for NYC for the first time.

### Clinic Roadshows: Citywide and Clinic-Specific Surveillance Data for 'Those Who Need to Know'

One of the key attributes of a surveillance system is the sharing of data with "those who need to know." That group includes both those who contribute to the collection of surveillance data and those who are in a position to act on it. In Fall of 2005, members of the Surveillance, Epidemiology and Research unit visited each of the Bureau's STD clinics to present data as part of a series known as the "Clinic Roadshows." Staff presented recent surveillance data for the major STDs reported in NYC, provided a national context for the data, and highlighted key behavioral data gleaned from interviews routinely conducted by clinic staff.

### Analysis of a Citywide Survey of NYC Health Care Providers

In 2005, the Bureau completed a survey to assess STD diagnosis and management practices of physicians and mid-level providers caring for NYC residents. One of the

key survey results indicated that almost half of New York City providers surveyed reported ever using patient-delivered partner treatment (PDPT) for chlamydia or gonorrhea infection. PDPT is a strategy of partner management whereby a patient diagnosed with an STD is given medication or a prescription to deliver to his or her sex partner(s). More than a quarter of providers reported that they used PDPT frequently. A manuscript describing the findings regarding PDPT has been accepted for publication in a peer-reviewed scientific journal and a second manuscript regarding STD screening practices is underway.

### In-Depth Survey of Sexual Behavior, HIV Disclosure Practices, and Drug Use Concluded

In early 2005 the Bureau concluded enrollment for a study on these topics, done in collaboration with investigators at New York University. Results from this study will be available in the 2006 Annual Report.

### Epidemiologic Investigation of Neonatal Herpes Cases Occurring After Religious Circumcision

During 2005 the Bureau investigated cases of neonatal herpes that were found to be linked epidemiologically to a religious circumcision practice known as *metzitzah b'peh*, which includes oral suctioning of the fresh circumcision wound. The Bureau issued a Health Alert, disseminated in December 2005, which called upon providers to suspect herpes infection in male infants presenting with vesicular lesions on the genitals, perineum, buttocks, or related dermatomes in the weeks after circumcision. The alert also requested Department of Health notification of such cases within 24 hours of diagnosis.

### Neonatal Herpes Surveillance

Using a statewide hospitalization database to identify infants aged <6 weeks at admission, who were discharged from a NYC hospital with neonatal herpes during 1994-2003, the Bureau estimated the annual incidence of neonatal herpes at 13.4/100,000 live births (or approximately 1 in 7,500 live births) per year. In addition, the NYC Board of Health approved mandatory reporting of herpes diagnosed in infants ≤60 days.

# Profile of Selected Sexually Transmitted Diseases

## Important Trends in Syphilis, Gonorrhea, and Chlamydia

**TABLE 1**

Primary & Secondary Syphilis, Gonorrhea, and Chlamydia Cases and Case Rate per 100,000 Persons, by Sex, Age, Race/Ethnicity, and United Hospital Fund (UHF) Neighborhoods, New York City, 2005

	P&S Syphilis		Gonorrhea		Chlamydia	
	N	Rate	N	Rate	N	Rate
<b>Cases*</b>						
Female	22	0.5	5051	119.9	26946	639.4
Male	594	15.7	5540	146.0	12242	322.7
<b>Age Groups†</b>						
0–9 yrs	0	0.0	10	0.9	73	6.6
10–14 yrs	0	0.0	95	17.9	420	79.1
15–19 yrs	26	5.0	2359	453.1	11485	2205.9
20–24 yrs	65	11.0	3013	510.8	13175	2233.7
25–29 yrs	73	10.7	1931	283.7	6840	1004.9
30–34 yrs	111	16.2	1160	168.8	3286	478.1
35–39 yrs	138	20.9	818	123.8	1764	266.9
40–44 yrs	114	18.9	586	97.3	976	162.0
45–49 yrs	56	10.5	292	55.0	453	85.3
50–54 yrs	19	4.0	136	28.3	233	48.4
55–59 yrs	7	1.9	50	13.6	116	31.4
60–64 yrs	2	0.6	26	8.3	48	15.3
65+ yrs	5	0.5	28	3.0	102	10.9
<b>Race/Ethnicity‡</b>						
Asian/Pacific Islander	10	2.0	859	15.5	3086	134.3
Black	306	11.4	6992	399.7	22690	1065.1
Hispanic	131	8.7	1717	79.8	10950	422.4
Native American/Alaskan Native	2	17.6	138	194.2	357	521.0
White	155	5.2	642	21.8	1338	43.3
Other Race/Ethnicity	12	44.1	201	361.8	983	1400.1
<b>UHF Neighborhoods§</b>						
<b>BRONX</b>	67	5.0	2319	174.7	9339	703.4
Crotona	11	5.5	433	217.0	1575	789.4
Fordham	15	6.0	370	147.7	1534	612.4
Kingsbridge	a	b	48	53.9	215	241.6
Morrisania	7	3.7	499	263.0	1654	871.1
Mott Haven	13	10.6	251	204.3	972	791.0
Northeast Bronx	a	b	250	134.4	1087	584.4
Pelham	13	4.5	400	137.9	2064	711.6
Unknown	2		68		238	

\* Cases in which sex is unknown have been proportionally distributed into both gender categories

† Cases with unknown age excluded

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

§ Cases with unknown residence excluded

<sup>a</sup> Denotes 5 or fewer cases at the neighborhood level

<sup>b</sup> Indicates the corresponding case rate for ≤5 cases

TABLE 1 (CONTINUED)

	P&S Syphilis		Gonorrhea		Chlamydia	
	N	Rate	N	Rate	N	Rate
<b>UHF Neighborhoods<sup>s</sup> (Continued)</b>						
<b>BROOKLYN</b>	182	7.4	3865	156.8	13460	546.0
Bensonhurst	6	3.1	46	23.6	210	107.9
Borough Park	a	b	92	28.4	412	127.0
Canarsie	10	5.1	271	137.0	1081	546.5
Coney Island	a	b	172	60.0	607	211.6
Crown Heights	54	17.0	1084	341.6	3310	1043.2
Downtown Heights	21	9.8	292	136.0	771	359.1
East Flatbush	27	8.5	700	221.0	2821	890.7
East New York	9	5.2	480	276.3	1643	945.8
Greenpoint	20	16.1	96	77.1	296	237.8
Sunset Park	a	b	47	39.0	325	269.8
Williamsburg	24	12.4	492	253.2	1589	817.8
Unknown	2		93		395	
<b>MANHATTAN</b>	277	18.1	2371	155.0	7535	492.7
Central Harlem	38	25.1	464	307.1	1320	873.5
Chelsea	75	61.0	350	284.6	545	443.1
East Harlem	22	20.4	233	215.6	836	773.4
Gramercy Park	21	16.9	134	107.7	325	261.1
Greenwich Village	17	20.3	176	210.3	817	976.0
Lower Manhattan	a	b	44	142.4	118	381.9
Union Square	27	13.7	198	100.4	537	272.4
Upper East Side	8	3.7	111	50.9	261	119.6
Upper West Side	18	8.1	171	77.0	481	216.6
Washington Heights	41	15.1	281	103.8	1414	522.4
Unknown	7		209		881	
<b>QUEENS</b>	83	3.7	1839	82.0	8061	359.5
Astoria	16	7.2	131	59.3	506	229.0
Bayside	a	b	24	27.2	72	81.7
Flushing	a	b	51	20.0	330	129.1
Forest Hills	7	2.9	73	30.3	335	139.1
Fresh Meadows	a	b	24	25.8	165	177.1
Jamaica	13	4.6	452	158.3	1651	578.1
Rockaway	a	b	146	136.8	443	415.0
Southeast Queens	6	2.9	225	110.5	876	430.1
Southwest Queens	a	b	136	50.4	638	236.3
West Queens	30	6.3	481	100.7	2625	549.7
Unknown	1		96		420	
<b>STATEN ISLAND</b>	7	1.6	202	45.5	820	184.8
Port Richmond	a	b	58	92.4	269	428.4
South Beach	a	b	31	17.2	92	51.1
Stapleton	a	b	91	78.3	360	309.7
Willowbrook	0	0.0	12	14.1	63	74.3
Unknown	0		10		36	
<b>NEW YORK CITY TOTAL</b>	<b>616</b>	<b>7.7</b>	<b>10596</b>	<b>132.3</b>	<b>39215</b>	<b>489.7</b>

## Primary & Secondary (P&S) Syphilis

**TABLE 2**

Primary & Secondary Syphilis Cases and Case Rate per 100,000 Persons, by Race/Ethnicity and Sex, with Median Age, New York City, 2005\*

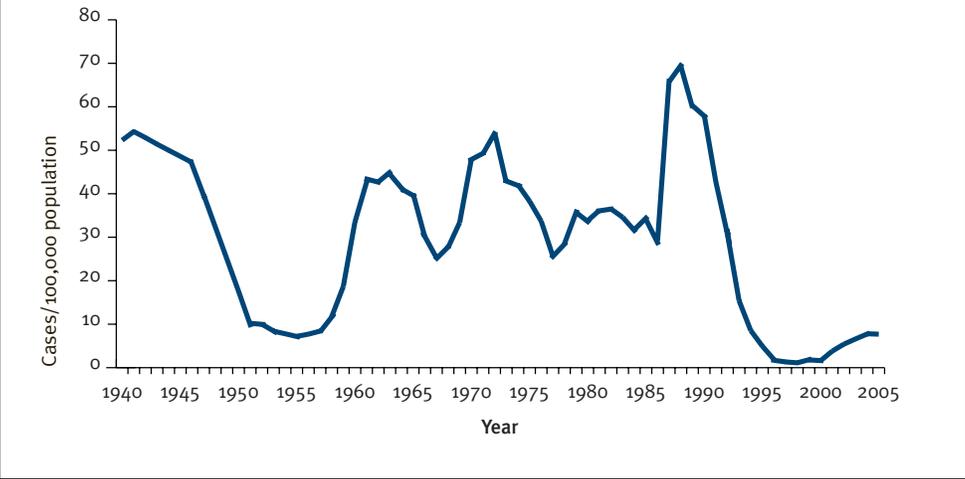
<b>Race/Ethnicity</b>	<b>N</b>	<b>Rate/100,000</b>	<b>Median Age<sup>§</sup> (years)</b>
<b>Asian/Pacific Islander</b>			
Female	0	0.0	
Male	10	2.57	33.5
<b>Black</b>			
Female	7	0.67	39
Male	297	33.97	33
<b>Hispanic</b>			
Female	12	1.09	40
Male	122	11.70	35
<b>Native American/Alaskan Native</b>			
Female	0	0.0	
Male	2	20.35	41
<b>White</b>			
Female	2	0.17	41
Male	152	11.33	39.5
<b>Other Race/Ethnicity</b>			
Female	0	0.0	
Male	12	8.23	31
<b>Total</b>	<b>616</b>	<b>7.69</b>	<b>36</b>

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

§ Median age calculated based on cases with known age

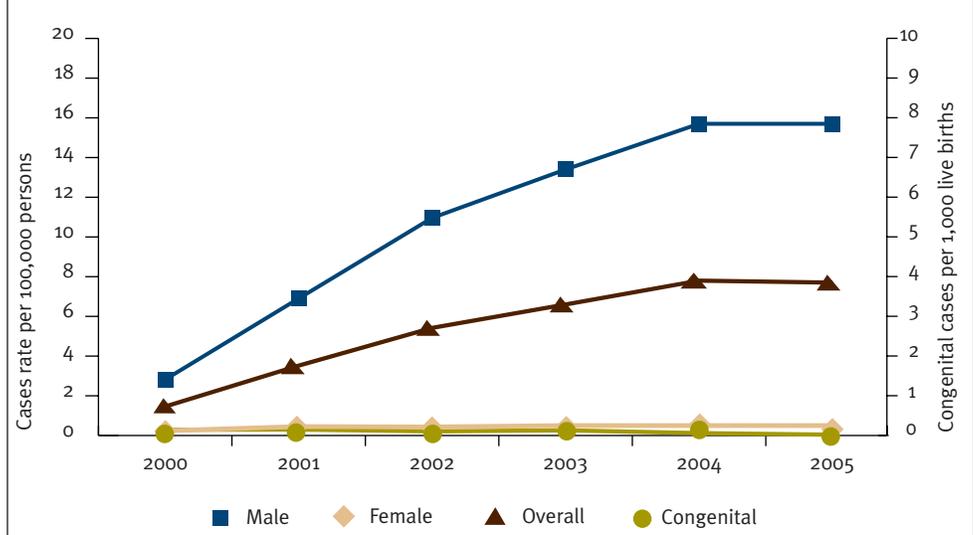
- Overall, NYC P&S syphilis case rates declined steadily between 1988 and 1998
- P&S syphilis peaked in 1988 at 69.3 cases per 100,000 population
- P&S syphilis dropped to its lowest point in 1998 at 1.1 cases per 100,000 population
- In 2005, P&S syphilis decreased in New York City for the first time since 1999

**Fig. 4**  
**P&S Syphilis Cases and Case Rate per 100,000 Persons, New York City, 1940–2005**



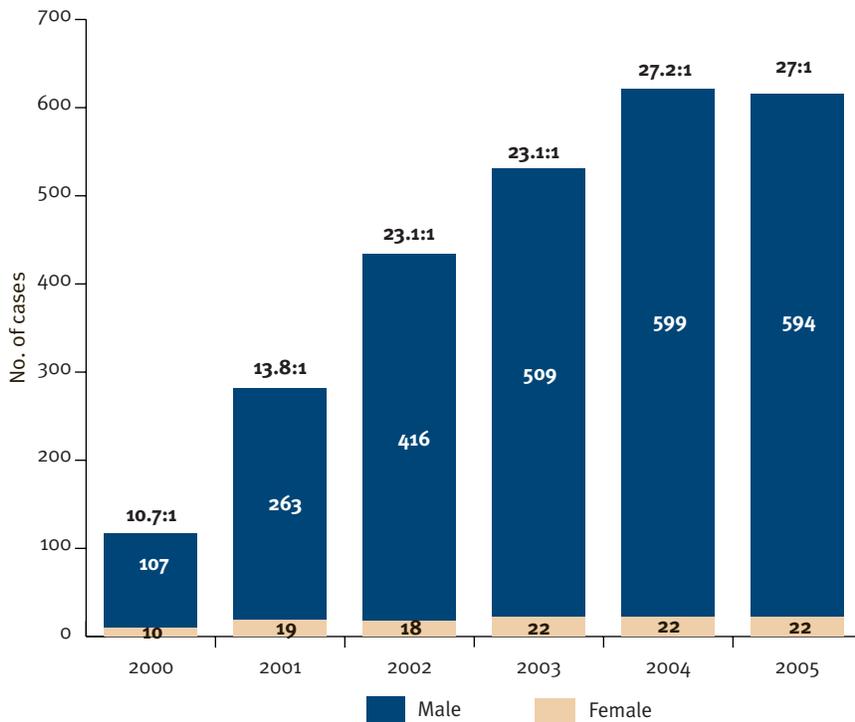
- In 2005, the overall NYC P&S syphilis case rate was 7.7 per 100,000 population (15.7/100,000 in men and 0.5/100,000 in women)
- From 2000-2004, P&S syphilis case rates increased among men
- From 2004-2005 the case rate remained stable at 15.7/100,000
- Congenital syphilis case rates remained low and relatively stable from 2000 through 2005

**Fig. 5**  
**P&S Syphilis Cases & Case Rate per 100,000 Persons, by Sex, & Congenital Syphilis Cases & Case Rate per 1,000 Live Births, New York City, 2000–2005\***



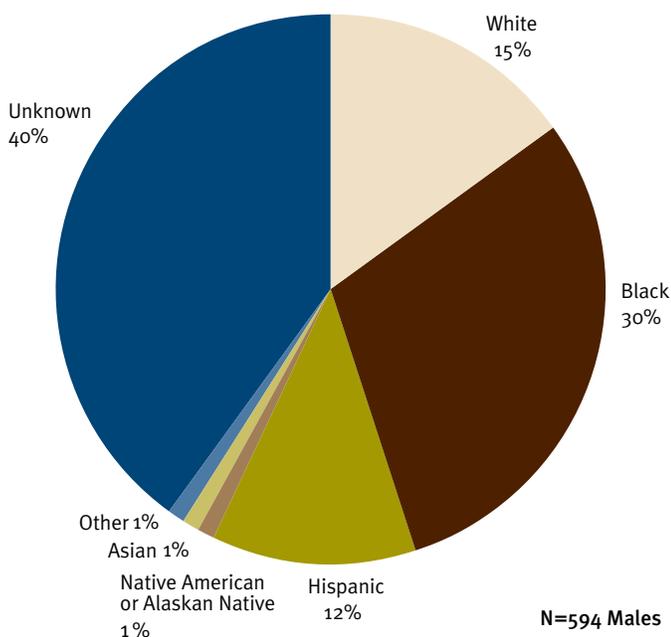
\* For 2005 congenital rate, live birth denominator based on annualized 2004 live birth data provided by NYC DOHMH Vital Statistics

**Fig. 6**  
P&S Syphilis Male-to-Female Case Ratio, New York City, 2000–2005



- Male-to-female case ratios increased considerably from 10.7:1 in 2000 to 27:1 in 2005
- In 2005, of 616 P&S syphilis cases citywide, 594 (96%) cases were among men
- 36 years was the median age of cases among men in 2005
- The current syphilis outbreak primarily affects men who have sex with men (MSM)

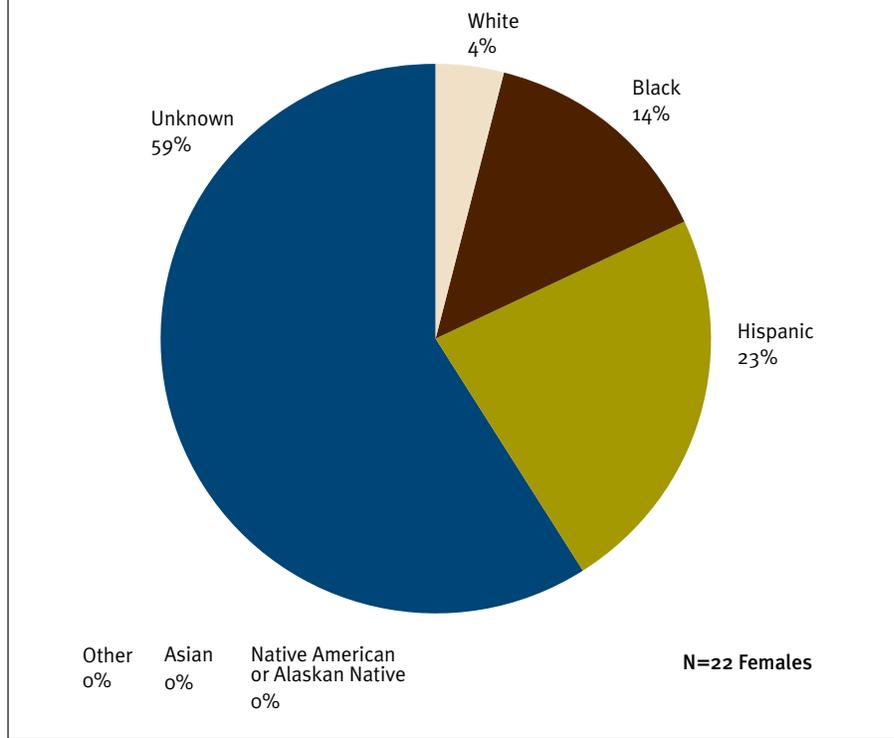
**Fig. 7**  
Male P&S Syphilis Cases, by Race/Ethnicity, New York City, 2005



- Race/ethnicity is unknown for more than 1/3 of cases in men
- In 2005, less than 1/5 of all male primary and secondary syphilis cases were known to be among non-Hispanic whites
- Over 1/4 of all male cases were known to be non-Hispanic Black, and about 1/8 of reported cases were known to be Hispanic

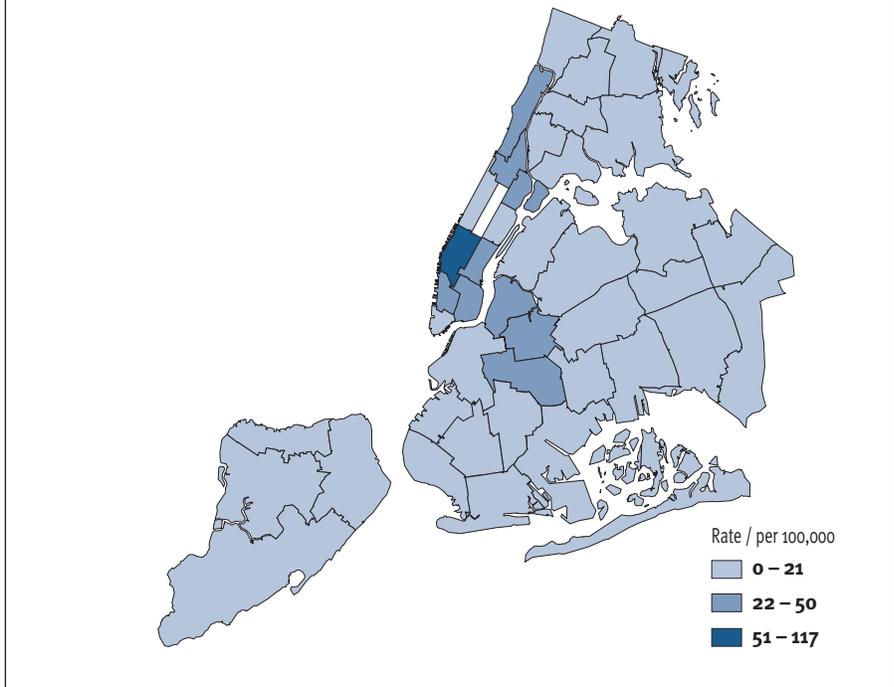
- More than 50% of P&S syphilis cases among women had no reported race/ethnicity
- Hispanic women accounted for almost 25% of cases overall
- Women of color (non-Hispanic black and Hispanic women) accounted for most cases for whom race/ethnicity was known

**Fig. 8**  
Female P&S Syphilis Cases, by Race/Ethnicity, New York City, 2005



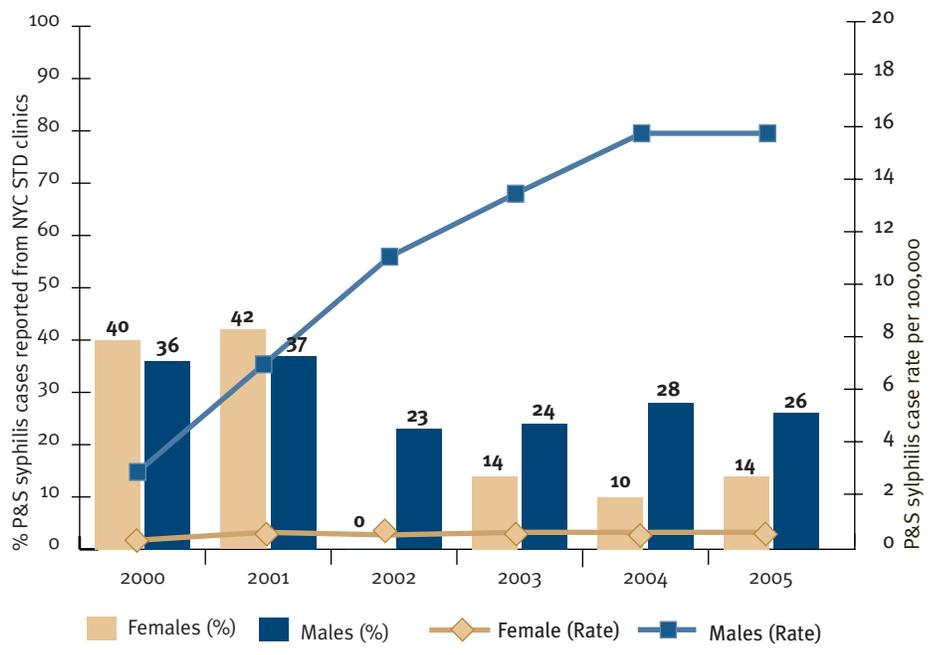
- The neighborhoods with the 4 highest P&S syphilis case rates were all in Manhattan:
  - Chelsea (117.4/100,000)
  - Central Harlem (50.4/100,000)
  - Greenwich Village (39.8/100,000)
  - East Harlem (39.0/100,000)

**Fig. 9**  
Male P&S Syphilis Case Rates per 100,000 Persons, by United Hospital Fund Neighborhood, New York City, 2005\*



\* For UHF Neighborhood names see Appendix B

**Fig. 10**  
**Proportion of NYC P&S Syphilis Cases Diagnosed and Reported by Public STD Clinics, by Sex, with Citywide Case Rates per 100,000 Persons, 2000-2005**



- Public STD clinics had historically diagnosed most P&S syphilis cases citywide
- Trends began to reverse in 1999
- DOHMH STD clinics currently account for less than 1/4 of all case reports
- In 2005, hospitals and private providers diagnosed and reported most cases of primary and secondary syphilis in New York City
- BSTDC clinics diagnosed 14% of cases among women and 26% among men

## Gonorrhea

**TABLE 3**

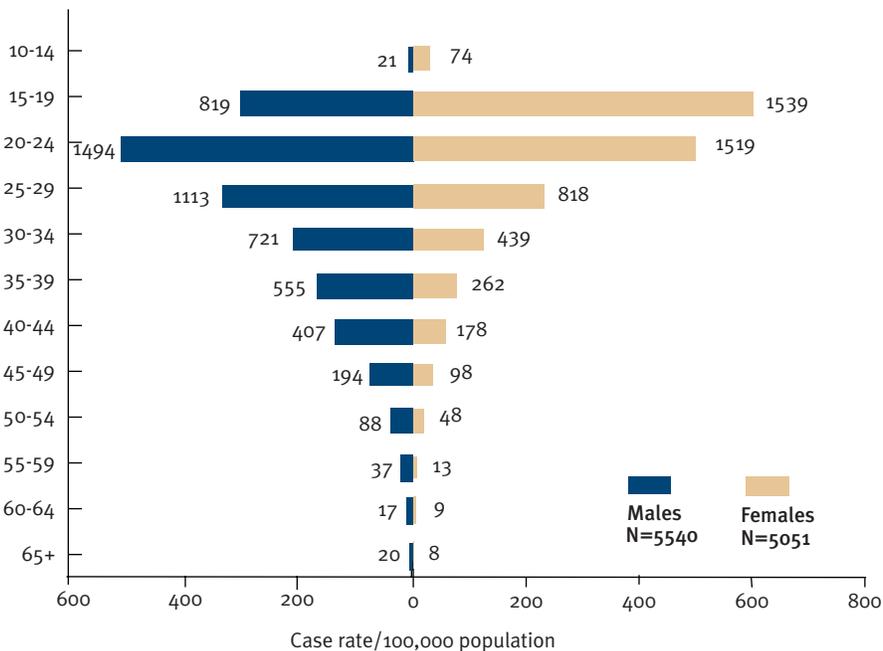
Gonorrhea Cases and Case Rate per 100,000 Persons, by Race/Ethnicity and Sex, with Median Age, New York City, 2005\*

<b>Race/Ethnicity</b>	<b>N</b>	<b>Rate/100,000</b>	<b>Median Age<sup>§</sup> (years)</b>
<b>Asian/Pacific Islander</b>			
Female	236	60.04	21
Male	607	155.93	25
<b>Black</b>			
Female	3514	323.0	21
Male	3506	400.98	25
<b>Hispanic</b>			
Female	970	86.62	22
Male	796	76.47	26
<b>Native American/Alaskan Native</b>			
Female	44	479.64	27
Male	90	1098.03	28.5
<b>White</b>			
Female	187	12.81	24
Male	444	33.14	30
<b>Other Race/Ethnicity</b>			
Female	102	71.89	25
Male	100	70.64	28
<b>Total</b>	<b>10596</b>	<b>132.31</b>	<b>24</b>

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

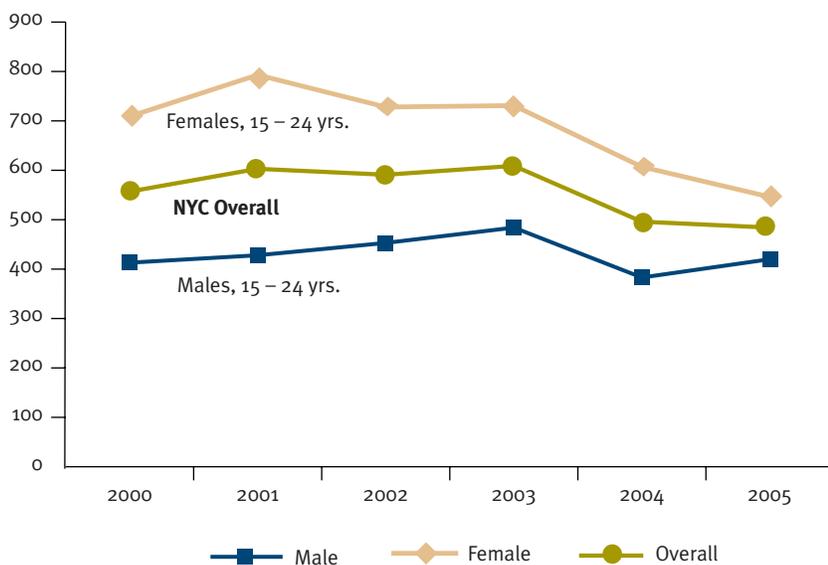
§ Median age calculated based on cases with known age

**Fig. 11**  
Gonorrhea Cases and Case Rate per 100,000 Persons, by Sex and Age, New York City, 2005



- In 2005, 10,596 cases<sup>§</sup> of gonorrhea were reported:
  - 5,540 in men
  - 5,051 in women
- In 2005, the overall NYC gonorrhea case rate was 132.3 per 100,000 population (146.0/100,000 in men and 119.9/100,000 in women)
- Gonorrhea infection rates were highest among 20- to 24-year-old men and among 15- to 19-year-old women

**Fig. 12**  
Gonorrhea Case Rate per 100,000 Persons, All Ages, and Among Persons Aged 15–24 Years, by Sex, New York City, 2000–2005\*



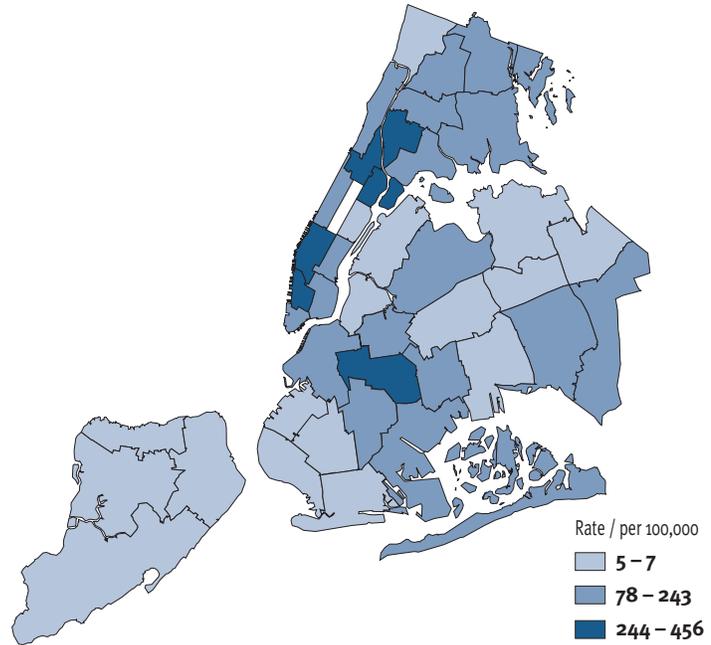
- Mirroring national trends, gonorrhea infection in young women aged 15-24 has slowly declined over the last 5 years
- After declining in 2004, gonorrhea cases increased among men in 2005

\* Case rates calculated using cases for which sex and age are known  
<sup>§</sup> Includes cases where sex is unknown

- Among the 5 New York City boroughs, male gonorrhea case rates were highest in Manhattan (211.7/100,000), exceeding the overall NYC rate among men (146.0/100,000)
- New York City neighborhoods with the highest case rates among men were:
  - Chelsea (455.6/100,000)
  - Central Harlem (414.8/100,000)
  - Crown Heights (380.9/100,000)

**Fig. 13**

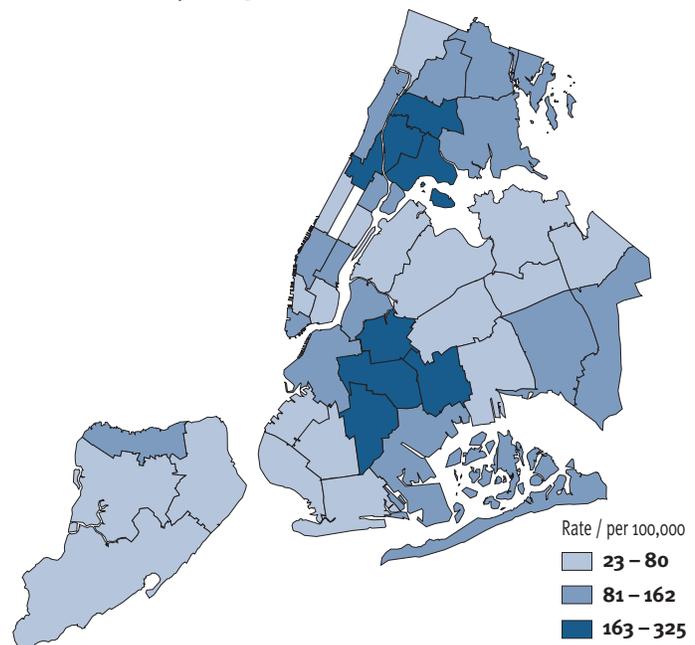
Male Gonorrhea Case Rates per 100,000 Persons, by United Hospital Fund Neighborhood, New York City, 2005\*



- Gonorrhea case rates among women in Brooklyn (159.8/100,000) and the Bronx (157.3/100,000) exceeded the overall New York City gonorrhea case rate among women (119.9/100,000)
- Three of the 5 New York City neighborhoods with the highest female gonorrhea case rates were in Brooklyn:
  - East New York (325.1/100,000)
  - Crown Heights (310.3/100,000)
  - Williamsburg (267.9/100,000)
- In the Bronx, Morrisania (228.8/100,000) and Crotona (219.6/100,000) had the highest female gonorrhea case rates

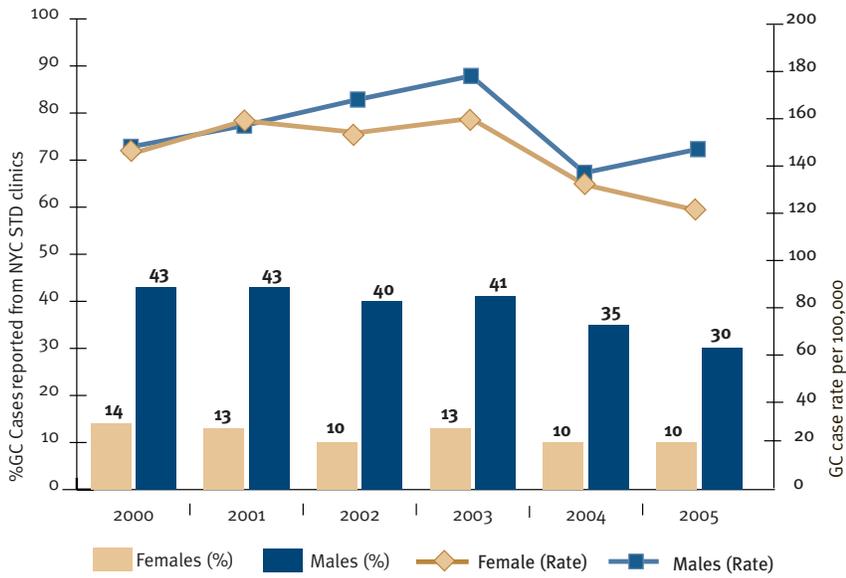
**Fig. 14**

Female Gonorrhea Case Rates per 100,000 Persons, by United Hospital Fund Neighborhood, New York City, 2005\*



\* For UHF Neighborhood names see Appendix B

**Fig. 15**  
**Proportion of New York City Gonorrhea Cases Diagnosed and Reported by Public STD Clinics, by Sex, with Citywide Case Rates per 100,000 Persons, New York City, 2000 – 2005**



- In 2005, most gonorrhea cases reported citywide (70% male and 90% female) were diagnosed and reported by hospitals and private providers
- The proportion of all gonorrhea cases in NYC diagnosed and reported from BSTDC clinics decreased slightly over the last 5 years

## Chlamydia

**TABLE 4**

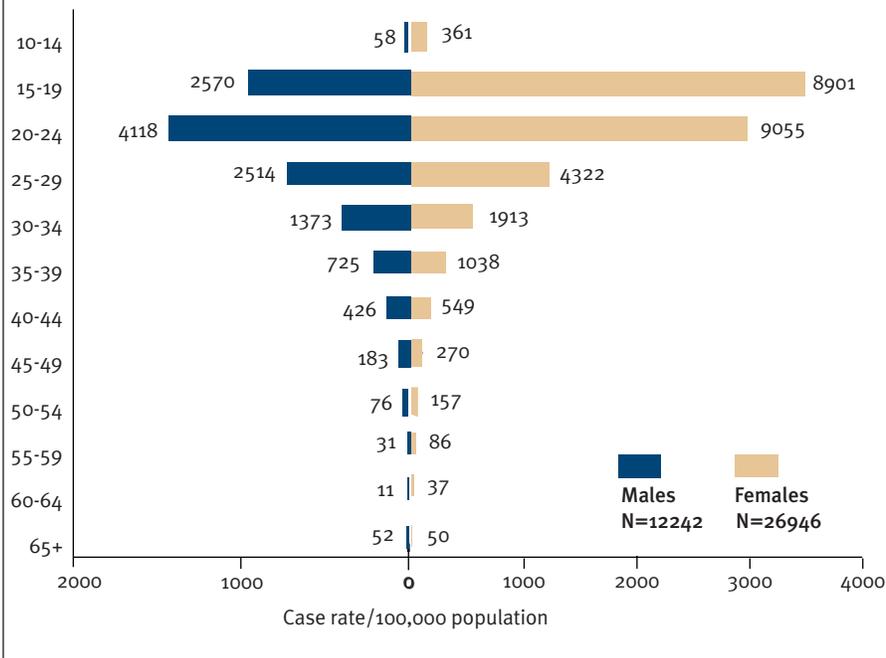
Chlamydia Cases and Case Rate per 100,000 Persons, by Race/Ethnicity and Sex, with Median Age, New York City, 2005\*

<b>Race/Ethnicity</b>	<b>N</b>	<b>Rate/100,000</b>	<b>Median Age<sup>§</sup> (years)</b>
<b>Asian/Pacific Islander</b>			
Female	1516	385.01	22
Male	1371	352.05	24
<b>Black</b>			
Female	15411	1416.61	21
Male	7165	819.59	23
<b>Hispanic</b>			
Female	8195	731.76	21
Male	2863	275.10	23
<b>Native American/Alaskan Native</b>			
Female	213	2330.59	21
Male	144	1755.29	26
<b>White</b>			
Female	855	58.52	22
Male	475	35.46	28
<b>Other Race/Ethnicity</b>			
Female	775	545.86	24
Male	232	163.63	25
<b>Total</b>	<b>39215</b>	<b>489.68</b>	<b>22</b>

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

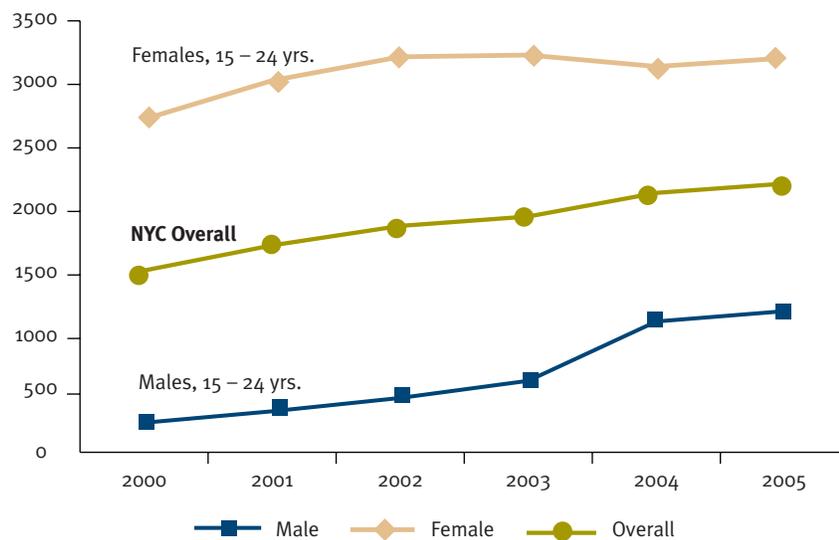
§ Median age calculated based on cases with known age

**Fig. 16**  
Chlamydia Cases and Case Rate per 100,000 Persons, by Sex and Age, New York City, 2005\*



- In 2005, 39,215 cases<sup>§</sup> of chlamydia were reported:
  - 12,242 among men and 26,946 among women
- In 2005, the overall NYC chlamydia case rate was 489.7 per 100,000 (322.7/100,000 in men and 639.4/100,000 in women)
- Adolescent women and young adults are affected disproportionately
  - 67% of all cases reported in NYC in 2005 were among women aged 15-24 years
- The high case rate among adolescent women is likely due to greater biological susceptibility to infection and the greater likelihood of being screened for asymptomatic disease, given existing screening guidelines

**Fig. 17**  
Chlamydia Case Rate per 100,000 Persons, All Ages and Among Persons Aged 15–24 Years, by Sex, New York City, 2000–2005\*



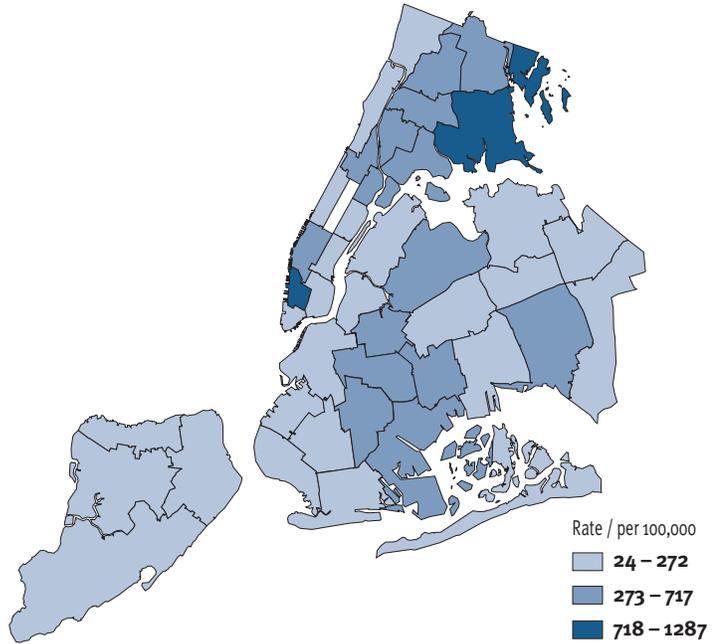
- Chlamydia case rates among women remained steady over the last 5 years
- Lower case rates among men, in general, reflect the fact that screening is still far less commonly performed for men than for women
- The increase in male cases reported over the past 5 years is likely due to more screening among men
- Implementation of male chlamydia screening at NYC correctional facilities has contributed substantially to the number of cases detected and reported in NYC

\* Case rates calculated for cases for whom sex and age are known  
<sup>§</sup> Includes cases where sex is unknown

- Male chlamydia case rates were highest in the boroughs of Manhattan (370.6/100,000) and the Bronx (497.2/100,000), exceeding the overall NYC case rate among men (322.7/100,000)
- The New York City neighborhoods with the highest male chlamydia case rates were:
  - Greenwich Village (1286.7/100,000)
  - Pelham (843.8/100,000)
  - Central Harlem (717.2/100,000)

**Fig. 18**

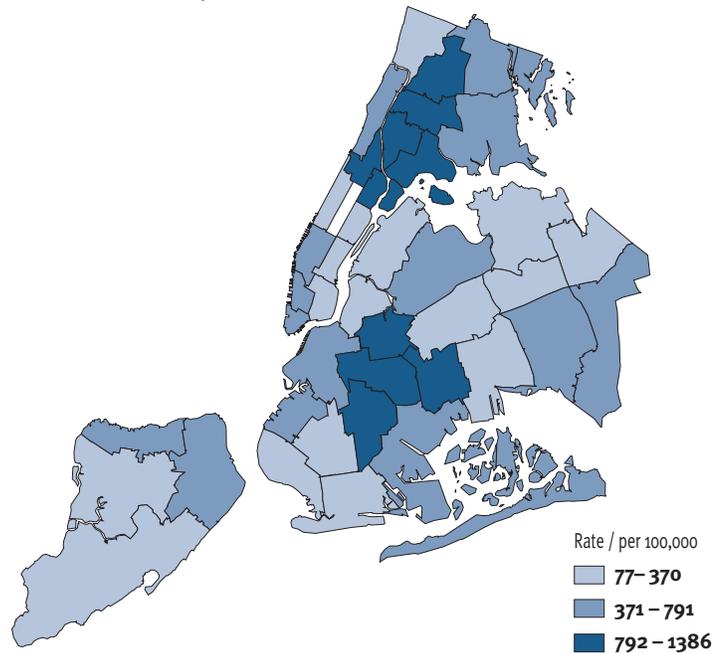
**Male Chlamydia Case Rates per 100,000 Persons, by United Hospital Fund Neighborhood, New York City, 2005\***



- Among the 5 New York City boroughs, the Bronx had the highest rate of female chlamydia cases (879.6/100,000)
- The New York City neighborhoods with the highest female chlamydia case rates were all in Brooklyn:
  - Crown Heights (1,385.8/100,000)
  - East New York (1,307.8/100,000)
  - East Flatbush (1,203.6/100,000)

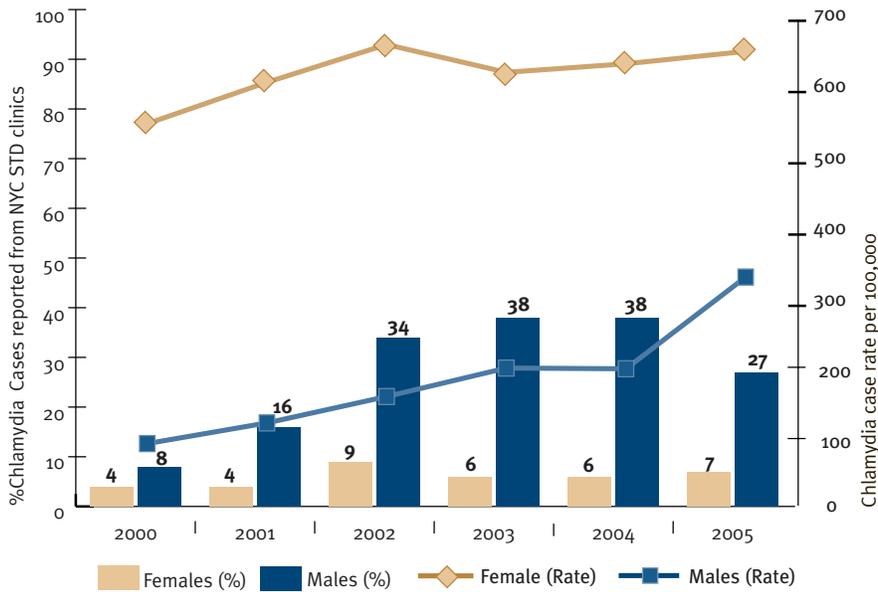
**Fig. 19**

**Female Chlamydia Case Rates per 100,000 Persons, by United Hospital Fund Neighborhood, New York City, 2005\***



\* For UHF Neighborhood names see Appendix B

**Fig. 20**  
**Proportion of New York City Chlamydia Cases Diagnosed and Reported by Public STD Clinics, by Sex, with Citywide Case Rates per 100,000 Persons, New York City, 2000–2005**



- Universal chlamydia testing for male patients attending BSTD clinics was introduced in 2002, and accounts for the increased proportion of cases diagnosed and reported from BSTD clinics during 2002-2004
- In 2005, male chlamydia screening was introduced in New York City correctional facilities; this increased the number of chlamydia cases reported Citywide, and decreased the proportion of male chlamydia cases reported from BSTD clinics

## Appendix A: Clinic Locations

Call 311 for hours of operation, locations,  
and services offered, or visit  
[www.nyc.gov/std](http://www.nyc.gov/std)

### Manhattan

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

### Bronx

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

### Brooklyn

- Bushwick  
335 Central Avenue (Linden St./Grove St.)  
Brooklyn, NY 11221
- Fort Greene  
295 Flatbush Avenue Extension, 2nd Floor  
(Willoughby/Fleet)  
Brooklyn, NY 11201

### Queens

- Corona  
34-33 Junction Boulevard (Roosevelt/Northern)  
Jackson Heights, NY 11372
- Jamaica  
90-37 Parsons Boulevard, 1st Floor  
(off Jamaica Avenue)  
Jamaica, NY 11432

### Staten Island

- Richmond  
51 Stuyvesant Place, 1st Floor (Wall Street)  
Staten Island, NY 10301

## Appendix B: United Hospital Fund Neighborhoods



## Appendix C: UHF Neighborhood-level data

The Bureau of STD Control uses United Hospital Fund (UHF) Neighborhoods to calculate neighborhood-specific case rates. UHF neighborhoods are defined by zip code, and for this STD Report are named as follows:

ZIP CODES	STD UHF Name
<b>BRONX</b>	
10463, 10471	Kingsbridge
10466, 10469, 10470, 10475	Northeast Bronx
10458, 10467, 10468	Fordham
10461, 10462, 10464, 10465, 10472, 10473	Pelham
10453, 10457, 10460	Crotona
10451, 10452, 10456	Morrisania
10454, 10455, 10459, 10474	Mott Haven
<b>QUEENS</b>	
11101, 11102, 11103, 11104, 11105, 11106	Astoria
11368, 11369, 11370, 11372, 11373, 11377, 11378	West Queens
11354, 11355, 11356, 11357, 11358, 11360	Flushing
11361, 11362, 11363, 11364	Bayside
11374, 11375, 11379, 11385	Forest Hills
11365, 11366, 11367	Fresh Meadows
11414, 11415, 11416, 11417, 11418, 11419, 11420, 11421	Southwest Queens
11412, 11423, 11430, 11432, 11433, 11434, 11435, 11436	Jamaica
11001, 11004, 11005, 11040, 11411, 11413, 11422, 11426, 11427, 11428, 11429	Southeast Queens
11691, 11692, 11693, 11694, 11697	Rockaway
<b>BROOKLYN</b>	
11211, 11222	Greenpoint
11206, 11221, 11237	Williamsburg
11201, 11205, 11215, 11217, 11231	Downtown Heights
11212, 11213, 11216, 11233, 11238	Crown Heights
11207, 11208	East New York
11220, 11232	Sunset Park
11204, 11218, 11219, 11230	Borough Park
11203, 11210, 11225, 11226	East Flatbush
11234, 11236, 11239	Canarsie
11209, 11214, 11228	Bensonhurst
11223, 11224, 11229, 11235	Coney Island
<b>MANHATTAN</b>	
10031, 10032, 10033, 10034, 10040	Washington Heights
10026, 10027, 10030, 10037, 10039	Central Harlem
10029, 10035	East Harlem
10023, 10024, 10025, 10069	Upper West Side
10021, 10028, 10044, 10128, 10162	Upper East Side
10001, 10011, 10018, 10019, 10020, 10036	Chelsea
10010, 10016, 10017, 10022, 10165, 10170, 10171	Gramercy Park
10012, 10013, 10014	Greenwich Village
10002, 10003, 10009	Union Square
10004, 10005, 10006, 10007, 10038, 10048, 10280, 10282	Lower Manhattan
<b>STATEN ISLAND</b>	
10302, 10303, 10310	Port Richmond
10301, 10304, 10305	Stapleton
10314	Willowbrook
10306, 10307, 10308, 10309, 10312	South Beach

## How to Report Sexually Transmitted Diseases

Prompt reporting of all diseases and conditions is important. Call the New York City Department of Health and Mental Hygiene at 1 (866) 692-3641 or visit [nyc.gov/nycmed](http://nyc.gov/nycmed) to report the following sexually transmitted diseases:

- Chancroid
- Chlamydia trachomatis infections (genitourinary and perinatal)
- Gonococcal infection (gonorrhea)
- Granuloma inguinale (donovanosis)
- Lymphogranuloma venereum
- Syphilis (all stages, including congenital)
- Neonatal herpes

Reports must be made within 24 hours of diagnosis or positive laboratory test result, indicating the presumptive presence of any of the diseases mentioned above. Reports should include:

- 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 or visit [nyc.gov/std](http://nyc.gov/std)

