EPIDEMIOLOGY SECTION

CONNECTICUT EPIDEMIOLOGIST

STATE OF CONNECTICUT DEPARTMENT OF HEALTH SERVICES
FREDERICK G. ADAMS, D.D.S., M.P.H., Commissioner

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HENOCH-SCHONLEIN PURPURA

Between August 13 and December 15, 1987, a cluster of 20 cases of Henoch-Schonlein Purpura (HSP) involving children under 10 years of age was identified in Connecticut. In contrast, eight cases had been identified in the state during the first 7 months of the year. HSP is a vasculitis of unknown etiology that involves the skin and other organ systems and primarily affects children.

The cluster was initially noted by a Hartford pediatric nephrologist who was consulted regarding eight children, four of whom became ill over a 2-week period. The Connecticut Department of Health Services then identified other cases by calling approximately 100 practicing pediatricians and members of all nine hospital pediatric departments in Hartford County. In addition, selected pediatric group practices and all teaching hospitals with pediatric or family practice training programs throughout the state were contacted.

Ten cases were identified in Hartford County, where case finding was the most intensive. Six of the ten patients lived in Hartford City and had onset of symptoms between October 15 and November 25 (attack rate for Hartford City, 2.9/10,000 children under 10 years of age). The other four lived in surrounding towns (0.5/10,000 children under 10 years of age). Hispanic children accounted for five cases in Hartford County and had an attack rate more than five times that of either black or white children (Hispanic children, 4.0/10,000; black children, 0.8/10,000; white children, 0.5/10,000). The ten cases outside of Hartford County involved eight white and two Asian children. No confirmed cases were found in Bridgeport, a city with a demographic composition similar to Hartford's.

All 20 children had a rash characteristic of HSP. Sixteen children developed arthritis, 16 had abdominal pain, and at least five had microscopic hematuria. Ten children were hospitalized. None died or developed serious complications.

To increase case finding, a letter requesting reports of all cases seen since January 1, 1987, has been sent to all pediatricians and all family practitioners in the state. A statewide case-control study to identify risk factors for acquiring the illness is under way.

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of the Director, Div of Viral Diseases, Center for Infectious Diseases; Div of Field Services, Epidemiology Program Office, CDC.

Editorial Note: HSP is identified by a characteristic rash most prominent on the buttocks and legs and is often associated with arthritis of the knee or ankle, abdominal cramping, or hematuria (1). As in this outbreak, the prognosis for the disease is generally good. However, a small percentage of children develop chronic glomerulonephritis (1,2). The number of children in the United States with renal failure resulting from HSP is unknown; however, one author has estimated that HSP is the cause of renal failure for 15% of the children on dialysis in Europe (3).

For many years, seasonal changes in the incidence of HSP have been noted; the largest number of cases usually occur in the winter (2,4). However, no previous cluster of cases has been reported. In addition, no predilection for Hispanic or urban children has been reported previously. HSP is believed to be caused by an immunologic response to a variety of different stimuli(5). In individual cases, it has been linked to foods (6), drugs (7), toxins (8), insect bites (9), and various infectious agents (10-13). Approximately two-thirds of the children in three large series of HSP reported symptoms of an upper respiratory infection during the month before onset (1,2,4). However, no agent was implicated as a cause of the symptoms. Investigation of clusters may identify agents responsible for causing HSP and may ultimately help in formulating strategies for prevention.

[Reprinted from MMWR 1988; 37:121-22. References available upon request.]

PENICILLIN-RESISTANT N. GONORRHOEAE TREATMENT ADVISORY

Since 1979, the number of cases of penicillin-resistant N. gonorrhoeae (PRGC) has been increasing steadily in several areas of Connecticut. By the end of 1987, two areas of the state - metropolitan New Haven and metropolitan Hartford - had reached a level of PRGC that the Centers for Disease Control describes as "hyperendemic"(1). For the year, 6.1% of all cases of gonorrhea in New Haven were PRGC, 3.8% in Hartford. Together, the two cities accounted for 70% of the 320 PRGC cases reported in the state.

The significance of reaching a hyperendemic level of penicillin-resistant gonorrhea is that antimicrobial agents other than penicillin, ampicillin or amoxicillin should be used for the initial treatment of suspected and confirmed cases of gonorrhea. Consequently, on the basis of the PRGC data for the New Haven and Hartford areas, the State Department of Health Services is issuing this treatment advisory.

The initial treatment regimen of choice for all uncomplicated cervical, uretheral, rectal and pharyngeal gonococcal infections occurring in the New Haven and Hartford areas, and for contacts to infected persons from these areas should now be:

Ceftriaxone: 125 mg IM

PLUS

Doxycycline: 100 mg, by mouth, twice a day for 7 days

OR

Tetracycline HCl: 500 mg, by mouth, four times a day for 7 days

Doxycycline or tetracycline is given as a supplement to eradicate possible coexistent chlamydial infection. Neither of these two drugs should be used alone for the treatment of gonorrhea. Better patient compliance may be found with the doxycycline regimen.

It is recommended that the 125-mg dose be given in the deltoid muscle, using a tuberculin syringe and 25-gauge needle, with either Lidocaine 1% or sterile water as a diluent.

The 125-mg dose is being recommended for the following reasons:

1. 98-100% effectiveness in treating uncomplicated gonorrhea, including the treatment of both plasmid and chromosomally mediated antibiotic-resistant strains (2);

2. Same effectiveness as 250-mg dose at half the cost;

3. Effective in the eradication of anal and pharyngeal gonorrhea (2);

4. Convenience of giving the injection in the deltoid muscle;

5. Probable effectiveness in aborting incubating syphilis.

Spectinomycin, previously the drug of choice for PRGC, should only be used if Ceftriaxone is contraindicated. Limitations of Spectinomycin compared to Ceftriaxone include less effectiveness against pharyngeal and anal gonorrhea, and ineffectiveness against incubating syphilis.

While the geographic extension of PRGC may subsequently occur in other areas of the state, health providers in areas not experiencing PRGC at hyperendemic levels are encouraged to continue using a penicillin regimen (Ampicillin, Amoxicillin, APPG) as the regimen of choice for treating patients with non-PRGC and their contacts. All patients suspected or confirmed as having uncomplicated PRGC should be given the Ceftriaxone regimen described above.

Health providers should refer to MMWR Sept. 11, 1987/Vol.36/No. 5S or CDC's 1985 STD Treatment Guidelines for recommendations on treating systemic, usually invasive, or pediatric gonococcal infections, as well as individuals for whom the regimen presented in this communication is contraindicated.

Prompt identification and reporting of PRGC is still essential to controlling its spread. To this end, all health providers are encouraged to continue applying the following recommendations:

* Culture all individuals having symptoms suggestive of gonorrhea, or any other sexually transmitted disease;

* Culture all individuals who have been exposed to gonorrhea, or any other sexually transmitted disease;

* Ensure that laboratory processing of gonorrhea cultures will include beta-lactamase testing on all gonococcal isolates;

* Encourage all gonorrhea infected patients to return within three to five days of completion of treatment for test-of-cure cultures;

AND

again four to six weeks after therapy for follow-up cultures to exclude possible reinfection;

* Immediately report cases of antibiotic-resistant gonorrhea by telephoning:

State STD Control Program

566-4493

Further information and consultation can be obtained by calling the above number.

REFERENCES

1. CDC. Antibiotic-resistant strains of Neisseria gonorrhoeae. MMWR, September 11, 198:36 (Suppl):5S.

2. H. Hunter Handsfield, MD and Edward W. Hook, III., M.D. Ceftriaxone for treatment of uncomplicated gonorrhea; routine use of a single 125-mg dose in a sexually transmitted disease clinic. Sexually Transmitted Diseases, 1987; 14:17-2.

STAFF ASSIGNMENTS

We are pleased to welcome Dennis Dix to the Epidemiology Section. Dennis has replaced Barry Trostel as Program Coordinator of the Immunization Program. He has come to us with over twenty years of public health experience with the U.S. Public Health Service. His most recent assignment was Program Director of the State of Maine Immunization Program in Augusta, Maine. Other immunization assignments include Rochester, New York and Pittsburgh, Pennsylvania. He also served in the Smallpox Eradication Program at Accra, Ghana in West Africa. Early in his career he spent 5 years in the Venereal Disease (STD) Program in New York City and in Albany, New York. Mr. Dix will be available to answer questions concerning immunization activities or issues in Connecticut at (203) 566-4141.

COMMUNICABLE DISEASES REPORTED

CONNECTICUT

WEEKS 1 - 18
(THROUGH MAY 6, 1988)

Name	1988	1987	% change from 1987
AIDS	135	67	+101.5
GONORRHEA	3316	3565	- 7.0
SYPHILIS P&S	191	97	+ 96.9
MEASLES	1	4	- 75.0
RUBELLA	-	-	-
TUBERCULOSIS	34	59	- 42.4
HEPATITIS A	57	40	+ 42.5
HEPATITIS B	64	88	- 27.3
SALMONELLOSIS	196	617	- 68.2
SHIGELLOSIS	33	53	- 37.7

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