Expedited Partner Tx for STDs Urged

BY KATE JOHNSON

MONTREAL — Expedited partner treatment, also known as patient-delivered partner therapy, could substantially reduce costs and morbidity from sexually transmitted diseases if it were allowed in all states, according to Dr. Margaret Villers.

The practice allows physicians who are treating patients with sexually transmitted diseases to either provide treatment, or write a prescription for their patients' partners without requiring the partners to come into the office.

Although the Centers for Disease Control and Prevention has encouraged expedited partner treatment (EPT) since 2006, it is explicitly legal in only 19 states, and "in multiple states and localities, there are legal barriers which may prevent universal implementation," Dr. Villers said at the annual meeting of the Infectious Diseases Society for Obstetrics and Gynecology. (For a map showing the legal status of EPT in each state, visit www.cdc.gov/std/ept/legal/default.htm.)

"The South Carolina statute very much mirrors the other states where it's prohibited in the sense that if you do not see a patient—if you've never met them, if you have not examined them, and if you do not have an ongoing relationship with them—then you are not allowed to prescribe a medication for them," explained Dr. Villers of the Medical University of South Carolina, Charleston.

In a cost-utility model examining the potential impact of EPT in 11 states where it was illegal in 2007 (one state, North Dakota, has since made the practice legal), she estimated there would be a cost savings of almost $6 million and the prevention of more than 2,000 cases of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* annually.

Using estimates of disease prevalence, treatment failure, costs, and quality-adjusted life years, EPT would have resulted in 984 fewer cases of chlamydia (rather than the actual 196,819 cases) and 1,280 fewer cases of gonorrhea (rather than the actual 56,585 cases). This reduction in disease would have resulted in a net savings of $1,671,387 for chlamydia and $4,163,534 for gonorrhea, and a combined gain of 453 quality-adjusted life years.

It is estimated that expedited partner treatment in 11 states could prevent more than 2,000 cases of *Chlamydia trachomatis* and *Neisseria gonorrhoeae* annually.

Currently, in the 19 U.S. states where EPT is explicitly legal, "there are state statutes that either allow for the provision of a prescription in general or specifically for the treatment of STDs only," she said. But there are 21 states where the laws are "somewhat murky. Either there are no laws, which means that presumably you can go ahead and provide this treatment" or there's nothing prohibiting treatment. She said that approximately 1 year ago the American Bar Association sent an open letter to all members encouraging states and localities to pass statutes that might decrease barriers to the implementation of EPT.

"Improved clarification of the legal status of EPT, whether it is a state law which only allows the prescription of medications for STDS or whether it is a broader general law, might actually make this type of treatment more acceptable to physicians," she said in an interview.

However, she said that both legal and clinical concerns are barriers to EPT. "Research studies have shown that there are few risks to partners who receive EPT and there are significant benefits. I think if the legal status of EPT was clarified, it would be much easier to educate physicians about its benefits," she said, noting that the logical places to prescribe EPT are health departments, which are usually state administered.

Dr. Villers noted that her study probably underestimates the benefits of EPT because it is based on the assumption that the infected patient was female, and was confined to the 3-month period following her treatment. Also we did not take into account multiple sexual partners, and we only looked at direct medical costs, not indirect costs, such as time off from work. ■

M. genitalium May Cause Cervicitis

BY KATE JOHNSON

MONTREAL — *Mycoplasma genitalium* is likely an underrecognized cause of some cases of cervicitis, but the role of the physician in screening for and treating this organism remains unclear, according to Dr. Harold Wiesenfeld of Magee-Womens Hospital and the University of Pittsburgh.

Dr. Wiesenfeld outlined his work showing a link between *M. genitalium* and subclinical pelvic inflammatory disease, as well as more recent findings implicating the organism in cervicitis, at the annual meeting of the Infectious Diseases Society for Obstetrics and Gynecology.

"Many cases, perhaps most cases, of cervicitis occur in women who are negative for the traditional pathogens known to cause cervicitis, such as *Neisseria gonorrhoeae* and *Chlamydia trachomatis*," he said in an interview. "Our findings may explain the etiology of cervicitis in some women."

His study of 524 women at risk for lower genital tract infection and undergoing testing for sexually transmitted disease found elevated polymorphonuclear leukocytes (PMNs), a microscopic marker for cervical inflammation, in 22% of the women. *M. genitalium* was identified in 8% of the overall cohort, but occurred more frequently among those with elevated PMNs compared with those without (37% vs. 21%). In fact, among all women with elevated PMNs, *M. genitalium* was the most common pathogen "eclipsing the more traditionally recognized cervicitis organisms," Dr. Wiesenfeld said.

In contrast, only 32% of those with elevated PMNs had *C. trachomatis*, 22% had *N. gonorrhoeae*, 22% had bacterial vaginosis, and 21% had *Trichomonas vaginalis*.

After logistic regression, infection with *M. genitalium* was independently associated with elevated PMNs, with an odds ratio of 2.5, he said.

"As there is an independent association between *M. genitalium* and cervical inflammation, it is likely that *M. genitalium* is the cause of a true cervical infection rather than just a colonizing organism," Dr. Wiesenfeld said. "I would not expect a colonizing organism to cause a cervical inflammatory response."

In order to rule out confounding STDs, the analysis was then restricted to 345 women who had tested negative for gonorrhea, chlamydia, and *Trichomonas* species. Eight percent of this cohort tested positive for *M. genitalium*, and 46% of this group had elevated PMNs compared with the 18 women who had no STD infections.

"After controlling for age, *M. genitalium* infection was independently associated with elevated PMNs with an odds ratio of 4.7," he said. Only a minority of women had clinical signs of cervicitis, and there were no clinical differences between those who tested positive or negative for *M. genitalium*.

The findings shed new light on the contributions of *M. genitalium* to cervicitis, but "at this point I do not think that these findings will change the routine management of cervicitis," Dr. Wiesenfeld said. ■

CA-MRSA Is a Rising Cause of Postpartum Mastitis

BY SHERRY BOSCHERT

SAN FRANCISCO — Postpartum mastitis and breast abscesses increasingly are being traced to community-associated infection with methicillin-resistant *Staphylococcus aureus*.

Fortunately, the risk of neonatal transmission or colonization in these cases is very low, and preliminary data suggest there's no increased risk of adverse neonatal outcomes even if the mother initially is given the wrong treatment for community-associated methicillin-resistant *S. aureus* (CA-MRSA), Dr. Natali Aziz said at a conference on antepartum and intrapartum management sponsored by the University of California, San Francisco.

In general, as many as one in three breastfeeding women in the United States develop postpartum mastitis, with approximately 10% of these developing breast abscesses. Studies of breast milk cultures have found *S. aureus* present in 37%-50% of mastitis cases.

A case-control study of 48 cases of *S. aureus*–associated postpartum mastitis in 1998-2005 found that 17 (81%) of 21 cases that were resistant to methicillin occurred in 2005 (Emerg. Infect. Dis. 2007;13:298-301).

Genetic analyses also suggested that 20 of the 21 MRSA cases were due to community-acquired MRSA, which may reassure clinicians that mastitis associated with MRSA should be susceptible to oral antibiotics, added Dr. Aziz of the university.

What few data exist on postpartum MRSA infection suggest that most cases involve mastitis or soft tissue infection, and that mastitis commonly leads to abscesses, she said.

In the largest study to date of hospitalized women with puerperal mastitis, cultures from 35 women who had both mastitis and breast abscesses found that CA-MRSA was the most common organism in breast abscesses, with MRSA in approximately two-thirds of cases. MRSA was much less likely in 54 women who had mastitis alone, growing in only one culture. As in the smaller study, a majority of women with CA-MRSA did not receive an appropriate antibiotic, but empiric use of an ineffective antibiotic did not adversely affect outcomes (Obstet. Gynecol. 2008;112:533-7).

At San Francisco General Hospital in 2005, *S. aureus* was cultured in the breast milk of 8 of 15 cases of mastitis; only 2 had MRSA, but three women with breast abscesses all had MRSA, Dr. Aziz said.

The data so far suggest that clinicians can continue to treat routine cases of mastitis with conventional first-line medications, and that it's reasonable to start treatment for CA-MRSA before cultures are completed in patients with abscesses or recurrent failure on conventional mastitis therapy. Consider getting cultures for recurrent disease, in areas with a high prevalence of CA-MRSA, or in patients with risk factors for CA-MRSA. "Be aware of your local epidemiology for your antibiotic choice" for CA-MRSA, Dr. Aziz advised, and remember that abscesses with CA-MRSA usually will require adjunct drainage or aspiration.

Women whose breast milk is colonized with CA-MRSA without mastitis can continue to breastfeed or pump breast milk for term infants, but this may put preterm infants at higher risk of conjunctivitis, sepsis, or other problems, some case reports suggest.

It is not cost effective to universally screen for MRSA or to decolonize women with MRSA in obstetric populations, a recent decision-analysis study concluded (Obstet. Gynecol. 2009;113:983-91). Dr. Aziz said she has no conflicts of interest. ■