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Screen Teens for Chlamydia

The latest figures on *Chlamydia trachomatis* screening suggest that many practitioners who see adolescents aren't giving the disease the attention that it deserves.

It's been 20 years since the U.S. Preventive Services Task Force (USPSTF) first recommended routine chlamydia screening of sexually active women aged 24 years and younger. Nonetheless, new data reported by the Centers for Disease Control and Prevention show that the screening rate in that population is still under 50%. This suggests that even though chlamydia is at or near the top of the list of sexually transmitted infections among our adolescent patient population, it's not as high on our radar screens.

This is worrisome. Of the approximately 1.1 million cases of chlamydia reported to the CDC in 2007, more than half were in females aged 15-25 years. We all realize that untreated chlamydia infections can progress to pelvic inflammatory disease (PID), infertility, and ectopic pregnancy, and that these infections are a common cause of chronic pelvic pain. But we also need to remember that because many infected adolescents have few if any symptoms, screening asymptomatic sexually active adolescents is the only way to maximize our chances of reducing the chlamydia disease burden.

The newly reported CDC data were obtained from reports of both commercial and Medicaid health plans to the Healthcare Effectiveness Data and Information Set (HEDIS) during 2000-2007. In 2007, chlamydia screening data were analyzed for 583 health plans with 2.8 million sexually active, continuously enrolled females. Nationally, the percentage of enrolled sexually active females aged 16-25 years who were screened for chlamydia increased from 25.3% in 2000 to 43.6% in 2006, but then decreased slightly to 41.6% in 2007 (MMWR 2009;58:362-9).

There was some geographic variation in 2007, with the highest screening rates in the Northeast (45.5%) and the lowest in the South (37.3%). Over the 7-year study period, screening increased the most in New Jersey (by 167.1%, from 15.2% of sexually active females screened in 2000 to 40.6% in 2007). Screening decreased, however, in several states between 2006 and 2007, with the greatest decline in Alabama (down by 26.4%, from 31.4% of sexually active females screened in 2006 to 23.1% in 2007). In 2007, Hawaii had the highest chlamydia screening rate (57.8%), and Utah had the lowest (20.8%).

Clinicians who see adolescents could make a big difference in ensuring that more of these patients receive screening. The cost of screening is relatively low, and the potential adverse effects of screening are few.

When screening these patients, take a social history without parents or family present so that you get the truest information about their sexual activity. Begin parent-free parts of the visit at the 11- to 12-year-old health maintenance visit or even during some ill visits so that the adolescent and family are accustomed to them. That way, this parent-free time will become routine, and parents won't become extra concerned when asked to leave the exam room.

Take all opportunities—sports physicals, precollege checkups, birth control visits, or even visits for mild acute illness—to recheck key aspects of sexual histories. This makes timely chlamydia screening possible for all of your sexually active teen patients. Expect the highest yield from teens with multiple partners in the recent past.

Acceptance of screening also may be affected by the screening method selected. Use of urethral swabs in males or speculum examination in females has not been well accepted by teens, and anxiety over the prospect of such could limit the sexual history information or spontaneous questions from adolescents. Less-threatening nucleic acid amplification tests are available and reliable. Some assays test for both chlamydia and *Neisseria gonorrhoeae* simultaneously. For young women, self-collected vaginal swabs result in samples that have been shown comparable in providing accurate chlamydia screening when compared with endocervical specimens obtained by care providers (J. Pediatr. Adolesc. Gynecol. 2008;21:355-60).

For males, urine-based screening has comparable sensitivity and specificity to those obtained via urethral swabs, with far better compliance (Ann. Intern. Med. 2005;142:914-25). Use of such noninvasive testing seems important in minimizing the discomfort and embarrassment so as to not "scare off" teens who may need repeated care.

I want to make a plea to screen male as well as female sexually active patients. I disagree with the USPSTF's 2007 decision that there is insufficient reason to screen males for chlamydia. The task force acknowledged that asymptomatic, untreated infections in males are a reservoir of infection that may make it difficult to reduce infections in women through screening programs that target only women. It seems shortsighted to turn a blind eye to male infection.

The USPSTF's view in 2007 was that, given the low national rates of screening in women at risk, "clinicians and health care systems should focus on improving the screening rates among women at increased risk, a group in which the benefits of screening are certain." I do not understand this dichotomy. We need to rethink our approach to chlamydia infections, remembering that males act as vectors to females and in some cases to other males, but also suffer frequent infections even if they do not often volunteer complaints.

As we see adolescents in our practices for whatever reasons, let's remember that chlamydia infections may produce mild or no symptoms. We must consider updating the sexual history of these patients without parents present. That way, we can offer screening for chlamydia (and other STD's) in a confidential manner with nonthreatening test assays to those who will benefit most. ■

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Officials Get Ready for 2009-H1N1 To Come Back in the Fall

Even as the rate of new 2009-H1N1 infections dwindles in the Northern Hemisphere, infection officials are bracing for the influenza's potential re-emergence this fall.

At press time, in response to a request from President Obama, David Obey (D-Wisc.), chair of the House Appropriations Committee, issued a statement supporting $2.05 billion in supplemental funding to increase surveillance of outbreaks and to purchase antivirals and antibiotics to help stop the spread of the infection.

Efforts are underway to develop a vaccine for 2009-H1N1. "We're taking those initial steps that are important and necessary should a vaccine [for 2009-H1N1] need to be made," said Dr. Richard E. Besser, acting director of the U.S. Centers for Disease Control and Prevention. "There are a lot of decisions that need to be made between now and" this fall, when people start receiving their flu shots.

Current gaps in knowledge about 2009-H1N1 are expected to be filled in the coming months as the flu season unfolds in the Southern Hemisphere. During this time, he said, epidemiologists will be seeking answers to several questions: How does the virus compete with other viruses that are circulating in the community? Does it change, and if so, in what way? Does it develop resistance?

If given the go-ahead, the bulk of vaccine production can start at the end of June, which means that the earliest a 2009-H1N1 vaccine will be available is in September, according to Klaus Stöhr, D.V.M., vice president and global head of Novartis Vaccines and Diagnostics Ltd. and former head of the World Health Organization's Global Influenza Program. Dr. Stöhr spoke at the international conference on Influenza Vaccines for the World held in Cannes, France.

The number of inoculations necessary will depend on how potent the vaccine needs to be, explained Dr. William Schaffner, chair of the department of preventive medicine at Vanderbilt University, Nashville, Tenn. In all likelihood, the 2009-H1N1 vaccine will require two shots to ensure immunity.

Couple that with the logistics of providing the seasonal influenza vaccine and "the potential for confusion is vast," he said in an interview.

Because people get immunized against the flu in so many different settings, it will be difficult to keep track of which shots an individual has actually received. It may help to make the 2009-H1N1 vaccine available only at public health clinics, but they are not staffed or organized to immunize a large portion of the population. It will also be quite difficult to track side effects specifically from the 2009-H1N1 vaccine.

The good news is that "what we're seeing so far is a fair amount of stability in the virus," Dr. Besser said.

At press time, virus isolates from the United States, Canada, Germany, Mexico, the Netherlands, and New Zealand had been genetically sequenced and "all of the genes examined were 99%-100% identical. This means it will be somewhat easier to produce an influenza vaccine," said Nancy Cox, Ph.D., chief of the influenza division at the CDC.

A lot could happen, however, between now and the fall. "We could see the current strain fizzle out and never come back again. We could see the current strain come back as it currently is, or we could see it mutate and come back in a more severe form. What we need to do during this period is make sure that we're prepared as a government, as a public health agency, [and] that our laboratories are ready should this come back as a much more severe infection," Dr. Besser said at a CDC press briefing.

So far, the genetic analysis of 2009-H1N1 has shown no sign of the virulence markers found in the 1918 pandemic influenza strain, also an H1N1 type, Dr. Cox said at CDC press briefing.

The 2009-H1N1 strain is "easily transmitted," with an attack rate of about 25%-30%, based on early analyses of person-to-person spread within families and households, said Dr. Anne Schuchat, the CDC's interim deputy director for science and public health programs. This attack rate is comparable to what is usually seen among most seasonal influenza strains.

—From staff reports