

Treat Male Partners of Teens Who Have an STI

BY DAMIAN McNAMARA

SAN ANTONIO — What makes researchers study the male partners of adolescent and adult women infected with a sexually transmitted infection? When their female patients get treated and return reinfected, it makes them think there must be a way to improve and deliver age- and partner-appropriate prevention messages.

"Once you diagnose an STI in an adolescent girl, you know there is at least one more person who has an STI," Dr. Andrea Thurman said. "I was treating girls who I knew were taking their medication but kept coming back.

"They were getting reinfected by their partners. I don't think these male partners were getting treated," she said at the annual meeting of the North American Society for Pediatric and Adolescent Gynecology.

Dr. Thurman and her colleagues proposed that prevention messages targeted to male sexual partners based on the age of the woman might be more effective. So they looked for demographic and behavioral differences between partners of teenagers and partners of adult women. They compared the male partners of 152 adolescent girls (14- to 19-years-old, mean age 18 years) with the partners of 362 adult women (20 years and older, mean age 24 years).

All women in the study had a lab-verified, nonviral sexually transmitted infection (STI) diagnosis. "STIs are common in teens, and we cannot screen them enough," Dr. Thurman said. Prevalence might be as high as 25%, based on a study by Forhan et al. presented at the 2008 National STD Prevention Conference in Chicago.

As part of study participation, each woman was re-

quired to invite a male sexual partner from the previous 2 months to participate. Approximately half the men tested positive for an STI at intake. However, partners of teenage women were significantly more likely to have such an infection (57% vs. 47%), especially chlamydia (51% vs. 39%). The gonorrhea coinfection rates were not significantly different (13% vs. 11%), and syphilis affected 1% of male partners in both groups.

"It is unclear why these men partnered with teenagers were more infected," Dr. Thurman said. It was not exposure, she added. "We thought that teens were having more sex, but the mean number of sexual acts in past 3 months was not significantly different between partners of teens, 68, and partners of adults, 62."

The mean age of partners of teenage women was 21 years versus 26 years for the partners of adults. Partners of teenage women were more likely to have less money and a higher number of partners; they were more likely to report current drug use and fewer had a high school education. In addition, partners of teens were more likely to be unmarried and not live with the index woman.

"These are things that we all assume, but it was interesting to look at [more than] 500 couples and see what is going on in their relationships, and what they are thinking," Dr. Thurman said.

Mean length of monogamy was 10 months for partners of teenagers versus almost 20 months for partners of adult women. "The guys dating the teenagers are like

the girls—they are sampling around," said Dr. Thurman of the University of Texas Health Sciences Center, San Antonio.

"Men partnered with teens were significantly more likely to report using any drug, including marijuana, within 1 month," Dr. Thurman said. A total of 95 (63%) partners of teenagers reported recent drug use versus 158 (44%) men dating adult women.

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DR. THURMAN



The researchers found a significant difference in reported condom use: A total of 41 (47%) of 88 partners of teenagers said they did not use condoms, compared with 69 (32%) of 215 partners of adult women specifically because "they like the sensation of 'skin on skin,'" Dr. Thurman said. "Keep this in mind when counseling teenage women—they may have different issues than adult women."

In some cases, when a woman tests positive for an STI, she agrees to notify her partner. Another approach is provider referral. "Someone from the ob.gyn. [office] calls and says an anonymous woman tested positive for chlamydia, and they offer to call in a prescription for him. The more I do this, the more men appreciate this," she said.

A meeting attendee asked how often Dr. Thurman encounters an infected woman who does not know the partner's last name or address. "Not so much in this study," she replied. "This was a self-selected group of women who already tested positive for an STI."

Dr. Thurman had no conflicts of interest. ■

Experts Suggest Schools as Likely H1N1 Vaccination Sites

BY HEIDI SPLETE

BETHESDA, MD. — The most likely scenario involving the influenza A(H1N1) virus this fall is that young people in schools will be disproportionately affected, said Dr. Anne Schuchat, director of the National Center for Immunization and Respiratory Diseases at the Centers for Disease Control and Prevention.

"We might need to offer interventions to people who aren't used to getting even a seasonal influenza vaccine," Dr. Schuchat said during a breakout session on vaccine preparation and distribution at an H1N1 Influenza Preparedness Summit sponsored by the National Institutes of Health.

[Since the session, children were named one of the target groups for priority H1N1 vaccination by the CDC's Advisory Committee on Immunization Practices (see page 1)].

The CDC's H1N1 Vaccine Task Force developed a guidance document with a best-case planning scenario, so clinicians have some idea what might unfold if the number of H1N1 viral infections surges in the fall.

The document describes likely target populations and presents ideas for where and how the H1N1 vaccines could be administered.

Students and staff associated with schools, children aged 6 months and older, child care center staff, and health care workers would be among those on the high-priority list in the likely event that the vaccine's availability is limited. In a best-case scenario, students would be vaccinated at schools and child care centers, and health care workers would be vaccinated in their work environments.

The goal in any emergency is to "keep our children safe and keep them learning," Arne Duncan, secretary of the Department of Education, said at the summit's morning session. School closings are a last resort, and more guidance is needed at the local level to help schools make informed decisions about what level of illness merits a closing. However, "most school districts have developed good emergency plans," he added.

Health and Human Services Secretary Kathleen Sebelius encouraged everyone—clinicians and the public—to visit www.flu.gov for the latest information on flu preparedness.

The presenters had no financial conflicts to disclose. ■

The guidance document is available at www.cdc.gov/h1n1flu/vaccination/statelocal/planning.htm.

School Survey: Oseltamivir Side Effects Affect Over 50%

BY JONATHAN GARDNER

More than half of children prescribed oseltamivir in three London schools with outbreaks of the novel virus influenza A(H1N1) experienced side effects, according to a survey.

Researchers from the British Health Protection Agency (HPA) and the European Centre for Disease Prevention and Control (ECDC) said 45 of 85 (53%) respondents prescribed prophylactic oseltamivir (Tamiflu) reported side effects from the antiviral medication (Euro. Surveill. 2009; 14:19287). The most common side effect was nausea, reported in 29% of cases (25 of 85), according to the researchers.

Frequent side effects reduce compliance and raise the risk of promoting antiviral resistance if lower drug concentrations only partly block virus replication, suggesting that governments in a disease containment mode not rely too much on antiviral drugs.

"The study findings formed part of the body of growing evidence that contributed to policy change in the U.K.," wrote the researchers, led by Aileen Kitching of the HPA London epidemiology unit and ECDC's European Program for Intervention Epidemiology Training. "Current U.K. advice is to limit antiviral prophylaxis in schools to the small number of contacts considered most at risk."

With a stockpile of 30 million doses of antiviral medication, the United Kingdom continued its containment strategy until July 2, 3 weeks after the World Health Organization declared a global pandemic. Until July 2, British physicians were offering oseltamivir to both patients and all exposed contacts.

Researchers asked the children at one primary school and two secondary schools, or their parents, to fill out an online survey form on side effects from oseltamivir. They sought responses from 256 children, of whom 103 responded. Of the respondents, 95 were estimated to have been offered oseltamivir, and 85 took any of the medication.

Of those 85, 56 respondents (66%) said they did or would complete the full course. A gastrointestinal side effect was reported by 40% of those on the medication. Nearly 18% reported at least one mild neuropsychiatric side effect (poor concentration/unable to think clearly, problems sleeping, feeling dazed/confused, bad dreams/nightmares, strange behavior). Neuropsychiatric side effects were more commonly reported by secondary (20%) than primary (13%) schoolchildren, the report noted.

The researchers said their findings are limited by a low response rate, which occurred because they asked for a response by the end of the day via a Web link that was sent to the families. ■