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 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/ep/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—you are not allowed to prescribe a medication for them,” explained Dr. Villers.

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.

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

CA-MRSA Is a Rising Cause of Postpartum Mastitis

BY SHERRY BOSCHERT

SAN FRANCISCO — Postpartum mastitis and breast abscesses are increasingly being traced to community-associated infection with methicillin-resistant Staphylococcus aureus (CA-MRSA), Dr. Natali Aziz said at a conference on antepartum and intra-partum 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.

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 among 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 mastitis 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 added.

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.

M. genitalium May Cause Cervicitis

BY KATE JOHNSON

MONTREAL — Mycoplasma genitalium is likely an unrecognized 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 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 “eliminating 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, and subclinical pelvic inflammatory disease, as well as more recent findings implicating the organism in the annual meeting of the Infectious Diseases Society for Obstetrics and Gynecology.

“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.