Update on Sexually Transmitted Infections

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Outline

- Syphilis in all its splendor
  - Postexposure prophylaxis: a desperate measure?
- Gonorrhea treatment: few and no new options
- Chlamydia: reappearance of LGV proctitis?
- Vaccinate: HBV/HAV, HPV, meningocococcus
- Screen: all relevant anatomic sites
Primary and Secondary Syphilis — Rates of Reported Cases by Age Group and Sex, United States, 2015

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Men Rate (per 100,000 population)</th>
<th>Women Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>0.0</td>
<td>0.1</td>
</tr>
<tr>
<td>15-19</td>
<td>8.0</td>
<td>2.8</td>
</tr>
<tr>
<td>20-24</td>
<td>35.7</td>
<td>5.1</td>
</tr>
<tr>
<td>25-29</td>
<td>41.8</td>
<td>4.5</td>
</tr>
<tr>
<td>30-34</td>
<td>29.9</td>
<td>2.9</td>
</tr>
<tr>
<td>35-39</td>
<td>22.6</td>
<td>2.3</td>
</tr>
<tr>
<td>40-44</td>
<td>17.1</td>
<td>1.5</td>
</tr>
<tr>
<td>45-54</td>
<td>15.4</td>
<td>0.9</td>
</tr>
<tr>
<td>55-64</td>
<td>5.7</td>
<td>0.3</td>
</tr>
<tr>
<td>65+</td>
<td>1.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>13.7</td>
<td>1.4</td>
</tr>
</tbody>
</table>
Syphilis rates among MSM: a timeline

Syphilis rates among MSM will soon be similar to those in the early 1980s

Peterman, 2015, *Expert Rev Anti Infect Ther*
* In 2015, 1,811 (57.7%) of 3,141 counties in the United States reported no cases of primary and secondary syphilis. Refer to the NCHHSTP Atlas for further county-level rate information: https://www.cdc.gov/nchhstp/atlas/.

Rate per 100,000 population:
- 0* (n=1,811)
- >0–2.8 (n=434)
- 2.9–6.4 (n=451)
- >6.4 (n=445)
Primary and Secondary Syphilis — Reported Cases by Sex, Sexual Behavior, and HIV Status, 31 States*, 2015

31 states were able to classify ≥70% of reported cases of primary and secondary syphilis as MSW †, MSM †, or women and ≥70% of cases as HIV-positive or HIV-negative during 2015.

† MSM = men who have sex with men; MSW = men who have sex with women only.
Ocular Syphilis — Eight Jurisdictions, United States, 2014–2015

Sara E. Oliver, MD1,2; Mark Aubin3; Leah Atwell, MPH4; James Matthias, MPH4,5; Anna Cope, PhD5,6; Victoria Mobley, MD6; Alexandra Goode, MSc7; Sydney Minnerly, MA8; Juliet Stoltey, MD9; Heidi M. Bauer, MD9; Robin R. Hennessy, MPH5,10; Dawne DiOrio, MPA5,11; Robyn Neblett Fanfair, MD12; Thomas A. Peterman, MD5; Lauri Markowitz, MD2

► 388 cases

► Most among MSM with HIV
  – A few among HIV-negative persons, including heterosexual men and women

► Several resulted in significant sequelae, including blindness

► All should be reported within 24 h of diagnosis to Public Health

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Suspected ocular syphilis</th>
<th>Total surveillance syphilis cases</th>
<th>% surveillance syphilis cases with suspected ocular syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>California*</td>
<td>48</td>
<td>60</td>
<td>6,238</td>
</tr>
<tr>
<td>Florida</td>
<td>10</td>
<td>32</td>
<td>6,030</td>
</tr>
<tr>
<td>Indiana†</td>
<td>—</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Maryland</td>
<td>10</td>
<td>17</td>
<td>1,524</td>
</tr>
<tr>
<td>New York City</td>
<td>14</td>
<td>12</td>
<td>5,798</td>
</tr>
<tr>
<td>North Carolina</td>
<td>21</td>
<td>42</td>
<td>1,799</td>
</tr>
<tr>
<td>Texas</td>
<td>27</td>
<td>16</td>
<td>7,337</td>
</tr>
<tr>
<td>Washington</td>
<td>27</td>
<td>44</td>
<td>857</td>
</tr>
<tr>
<td>Total</td>
<td>157</td>
<td>231</td>
<td>29,583</td>
</tr>
</tbody>
</table>

* California does not include syphilis reports from San Francisco or Los Angeles.
† Indiana reviewed data from 2015 only.
TABLE 2. Demographic characteristics of patients with suspected ocular syphilis — eight jurisdictions, United States, 2014–2015

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>388</td>
<td>(100.0)</td>
</tr>
<tr>
<td>Male</td>
<td>362</td>
<td>(93.3)</td>
</tr>
<tr>
<td>Known MSM (among 362 males)</td>
<td>249</td>
<td>(68.8)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>217</td>
<td>(55.9)</td>
</tr>
<tr>
<td>Black</td>
<td>81</td>
<td>(20.9)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>48</td>
<td>(12.4)</td>
</tr>
<tr>
<td>Asian</td>
<td>13</td>
<td>(3.4)</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific Islander</td>
<td>1</td>
<td>(0.3)</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>28</td>
<td>(7.2)</td>
</tr>
<tr>
<td>HIV-positive</td>
<td>198</td>
<td>(51.0)</td>
</tr>
</tbody>
</table>

Abbreviations: HIV = human immunodeficiency virus; MSM = men who have sex with men.

TABLE 3. Clinical characteristics, laboratory results and diagnoses for syphilis and suspected ocular syphilis — eight jurisdictions, United States, 2014–2015

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No.</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>388</td>
<td>(100.0)</td>
</tr>
<tr>
<td>Stage of syphilis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>8</td>
<td>(2.1)</td>
</tr>
<tr>
<td>Secondary</td>
<td>101</td>
<td>(26.0)</td>
</tr>
<tr>
<td>Early latent</td>
<td>79</td>
<td>(20.4)</td>
</tr>
<tr>
<td>Late or latent of unknown duration</td>
<td>193</td>
<td>(49.7)</td>
</tr>
<tr>
<td>Unknown</td>
<td>7</td>
<td>(1.8)</td>
</tr>
<tr>
<td>Additional symptoms of neurosyphilis</td>
<td>87</td>
<td>(22.4)</td>
</tr>
<tr>
<td>Reported ocular symptoms (among 326 with symptoms)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurry vision</td>
<td>210</td>
<td>(64.4)</td>
</tr>
<tr>
<td>Vision loss</td>
<td>107</td>
<td>(32.8)</td>
</tr>
<tr>
<td>Eye pain or red eye</td>
<td>46</td>
<td>(14.1)</td>
</tr>
<tr>
<td>Eye exam</td>
<td>158</td>
<td>(40.7)</td>
</tr>
<tr>
<td>Diagnosis (among 158 with documented eye exam)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uveitis</td>
<td>72</td>
<td>(45.6)</td>
</tr>
<tr>
<td>Retinitis</td>
<td>20</td>
<td>(12.7)</td>
</tr>
<tr>
<td>Optic neuritis</td>
<td>18</td>
<td>(11.4)</td>
</tr>
<tr>
<td>Retinal detachment</td>
<td>6</td>
<td>(3.8)</td>
</tr>
<tr>
<td>CSF analysis performed</td>
<td>188</td>
<td>(48.5)</td>
</tr>
<tr>
<td>CSF-VDRL (among 174 with a documented result)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reactive</td>
<td>122</td>
<td>(70.1)</td>
</tr>
<tr>
<td>Nonreactive</td>
<td>52</td>
<td>(29.9)</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aqueous penicillin G IV</td>
<td>230</td>
<td>(59.3)</td>
</tr>
<tr>
<td>Other treatment</td>
<td>146</td>
<td>(37.6)</td>
</tr>
<tr>
<td>No/Unknown treatment</td>
<td>12</td>
<td>(3.1)</td>
</tr>
</tbody>
</table>

Abbreviations: CSF = cerebrospinal fluid; IV = intravenous; VDRL = Venereal Disease Research Laboratory test.
* Can be included in multiple categories.
LP in HIV & Syphilis: Key Points

- Routine LP in HIV not recommended; base on history & examination
- CSF VDRL is insensitive (false negatives 30%-70%)
- Consider abnormality of any CSF parameter evidence for CNS involvement if serology is +, exam consistent, or known exposure
  - ↑ WBC (usually lymphocytes; not specific; >5 typical, but some authors have used >20 to account for HIV-related pleiocytosis)
  - ↑ Protein
  - + VDRL
  - + FTA/TPPA: very sensitive; not specific (helpful if negative)
Syphilis Treatment

• Penicillin preferred for all stages

• Early syphilis (primary, secondary, early latent)
  – BZN PCN (L-A) single dose IM 2.4 million units
    • Do not use other injectable PCN formulations
    • Do not use azithromycin (resistance; treatment failure)

• Late latent
  – BZN PCN (L-A) IM 2.4 million units weekly x 3 doses (7.2 million u total)

• Alternatives: doxycycline, ceftriaxone

CDC 2010 STD Treatment Guidelines www.cdc.gov/std
Open-label randomized trial enrolling 64 participants; mean CD4 388

Serologic treatment success 12 mos.
- 28 of 35 (80%) in single-dose regimen
- 27 of 29 (93%) in 3-dose regimen
- Per-protocol analysis: 93% vs 100%; absolute difference 7% (95% C.I. -7%, 22%); P = 0.49
- Not modified by CD4 count, RPR titer, syphilis stage

Not powered to demonstrate non-inferiority
Identified 1,693 reports in the literature, reviewed 20 studies that met selection criteria.

Median proportion of patients with serological nonresponse was 12.1% overall (interquartile range, 4.9–25.6)

Serofast proportion estimated from 2 studies, which ranged from 35.2%–44.4%. Serological cure primarily associated with younger age, higher baseline nontreponemal titers, and earlier syphilis stage.

Relationship between serological cure and HIV status inconsistent; among HIV-infected patients, CD4 count and HIV viral load not associated with serologic cure.
 Congenital Syphilis — Reported Cases by Year of Birth and Rates of Primary and Secondary Syphilis Among Women, United States, 2006–2015


Virginia Bowen, PhD1,2; John Su, MD, PhD3; Elizabeth Torrone, PhD2; Sarah Kidd, MD2; Hillard Weinstock, MD2
Key points

- We are in the middle of an impressive resurgent epidemic of STI, especially syphilis, in MSM
  - Considerable number of neurologic syndromes, including auditory, facial nerve palsy, visual abnormalities
- Among these infected MSM, at least half are co-infected with HIV
- Infection is occurring nationwide, across race/ethnicities
- Congenital syphilis events are still occurring
- Early syphilis PREDICTS HIV acquisition in those not already infected with HIV
A Vicious Cycle: STDs *predict* future HIV Risk

<table>
<thead>
<tr>
<th>Condition</th>
<th>HIV Diagnosis Rate within 1 Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rectal GC or CT</td>
<td>1 in 15 MSM</td>
</tr>
<tr>
<td>Primary or secondary syphilis</td>
<td>1 in 18 MSM</td>
</tr>
<tr>
<td>No rectal STD or syphilis infection</td>
<td>1 in 53 MSM</td>
</tr>
</tbody>
</table>

Of 2499 men, 360 (14.4%) RPR+ at screening; 333 (92.5%) confirmed

Syphilis incidence during trial: 7.3 cases/100 p-y

- No difference between study arms

HIV incidence varied by incident syphilis

- 2.8 cases /100 p-y for none vs 8.0

- Hazard ratio 2.6 (95% CI, 1.6–4.4; P <.001)

Clinical Infect Dis, 2014
A Vicious Cycle: STDs *predict* future HIV Risk

- Rectal GC or CT
  - 1 in 18 MSM were diagnosed with HIV within 1 year.
  - **Matched STD/HIV Surveillance Data, New York City. Pathela, CID 2015:61**

- Primary or secondary syphilis

- No rectal STD or syphilis infection
  - 1 in 53 MSM were diagnosed with HIV within 1 year.
  - *STD Clinic Patients, New York City. Pathela, CID 2013:57*

So what do we do while we wait for a vaccine?
On-Demand Post-Exposure Prophylaxis With Doxycycline for MSM: Follow on to IPERGAY

Open-Label Study (n = 232)
HIV-negative high-risk MSM enrolled in the open-label IPERGAY extension study
No contraindication to doxycycline

Randomization 1:1

On Demand PEP doxycycline 200 mg (~24 hours after sex, up to 72 hours)

No PEP

Visits: baseline and every 2 months
Serologic assays for HIV and syphilis
PCR assays for chlamydia and gonorrhea
Urine, anal, and throat samples collected

• Baseline characteristics:
  – Median age: 38-39 years
  – White: 95%
  – History of PEP use in IPERGAY: 19%.
  – Use of psychoactive drugs (ecstasy, crack, cocaine, crystal, speed, GHB/GBL): 42%
  – Circumcised: 21%
  – Prior gonorrhea, chlamydia, syphilis infection: 16%
  – Number of sexual acts in prior 4 weeks: 10

Time to First STI With On-Demand PEP With Doxycycline for MSM

Incidences of STIs (n = 73 with STI):
No PEP (n = 45): 70/100 person-years.
PEP (n = 28): 38/100 person-years.

Time to First Chlamydia and Syphilis with On-Demand PEP With Doxycycline for MSM


**Time to First Chlamydia (ITT)**

- Median follow-up: 8.7 months
- Incidence of chlamydia (n = 28):
  - No PEP (n = 21): 29/100 person-years.
  - PEP (n = 7): 9/100 person-years.
- HR: 0.30 (P = 0.003)

**Time to First Syphilis (ITT)**

- Median follow-up: 8.7 months
- Incidence of syphilis (n = 13):
  - No PEP (n = 10): 13/100 person-years.
  - PEP (n = 3): 4/100 person-years.
- HR: 0.27 (P = 0.04)
Time to First Gonorrhea with On-Demand PEP With Doxycycline for MSM

- **No effect on gonorrhea incidence**
- **Number sites of gonorrhea infection** (PEP vs no PEP)
  - Anus: 11 vs 19
  - Throat: 15 vs 12
  - Urine: 1 vs 7

Incidence of gonorrhea (n = 47):
- No PEP (n = 25): 35/100 person-years.
- PEP (n = 22): 29/100 person-years.

Conclusions

► PEP reduced overall incidence of bacterial STI by 47% in MSM on PrEP (8.7 months of follow-up)
► No effect on gonorrhea, but strong reduction in chlamydia and syphilis
► No evidence of sexual risk compensation
► Analysis of antibiotic resistance is pending
► Long-term benefit of PEP is not yet known
► Antibiotic prophylaxis for STIs still not recommended
► More research is needed

Penicillin cures gonorrhea in 4 hours.

See your doctor today.
* MSM = Gay, bisexual, and other men who have sex with men (collectively referred to as MSM); MSW = Men who have sex with women only.
2015 CDC STD Treatment Guidelines: Gonorrhea

Urogenital & pharyngeal infection:

- Ceftriaxone 250 mg injection x 1

PLUS:

- Azithromycin 2 g orally x 1

If CTX not available & urogenital infection
  - Cefixime 400 mg + azithromycin 1 g

If severe cephalosporin allergy
  - Gentamicin 240 mg IM + azithromycin 1 g

Doxycycline removed as second agent: >25% isolates are resistant
Cluster of Lymphogranuloma Venereum Cases Among Men Who Have Sex with Men — Michigan, August 2015–April 2016

Alex de Voux, PhD\(^1\),\(^2\); James B. Kent, MS\(^3\); Kathryn Macomber, MPH\(^3\); Karen Krzanowski, MA, MPH\(^4\); Dawn Jackson\(^5\); Tayneata Starr\(^6\); Sandra Johnson\(^4\); Deborah Richmond, MSN\(^5\); Lawrence R. Crane, MD\(^3\); Jonathan Cohn, MD\(^2\); Christopher Finch\(^3\); Jevon McFadden, MD\(^6\); Allan Pillay, PhD\(^2\); Cheng Chen, PhD\(^2\); Laurie Anderson\(^2\); Ellen N. Kersh, PhD\(^2\)

### BOX. Case definition of lymphogranuloma venereum (LGV) included in Michigan Health Alert Network sent out on October 22, 2015

**Suspected case**
- A clinically compatible illness in a person with one or more signs or symptoms compatible with LGV (proctocolitis, inguinal/femoral lymphadenopathy, or genital or rectal ulcers), and
- A sexual partner of a person meeting the probable or confirmed case definition.

**Probable case, either or both of the following:**
- A patient meeting the suspected case definition, in whom other causes of LGV-like symptoms (e.g., syphilis, gonorrhea, and herpes simplex virus) have been ruled out, and a positive *Chlamydia trachomatis* from culture or nucleic acid amplification test (NAAT) from a body site associated with symptoms.
- Sexual partner of a person meeting the probable or confirmed case definition and a positive *C. trachomatis* from culture or NAAT.

**Confirmed case**
- A probable case with laboratory confirmation for *C. trachomatis* genotypes L1, L2, or L3 by genetic analysis (LGV-specific polymerase chain reaction or sequencing).

- 38 cases reported to CDC
- All in HIV+ MSM
- Median CD4 483
- Suspect in severe or persistent proctitis, especially if lymphadenopathy is present
- Treat with doxycycline 100 mg bid x 3 weeks
- Report to local health department
“STI” Immunizations in HIV

► Hepatitis A/B

► Either 9vHPV or 4vHPV vaccination through age 26 years if not vaccinated previously

► Meningococcal vaccine
  – MenACWY-D (Menactra) or MenACWY-CRM (Menveo)

TABLE 1. Evidence of increased risk for meningococcal disease among HIV-infected persons compared with HIV-uninfected persons — seven study populations, 1996–2013

<table>
<thead>
<tr>
<th>Period</th>
<th>Study site</th>
<th>Age group</th>
<th>No. of cases</th>
<th>Increase in meningococcal disease rate among HIV-infected compared with HIV-uninfected persons</th>
<th>Serogroups</th>
<th>Serogroups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996–1999</td>
<td>Australia†</td>
<td>All ages</td>
<td>60</td>
<td>5-fold</td>
<td>B, C</td>
<td></td>
</tr>
<tr>
<td>1990–2000</td>
<td>London§</td>
<td>All ages</td>
<td>2,900</td>
<td>14-fold</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>1988–1993</td>
<td>Atlanta, Georgia¶</td>
<td>18–45 years</td>
<td>132</td>
<td>24-fold</td>
<td>B, C, Y</td>
<td></td>
</tr>
<tr>
<td>2003–2007</td>
<td>South Africa**</td>
<td>All ages</td>
<td>504</td>
<td>11-fold</td>
<td>A, B, C, W, Y</td>
<td></td>
</tr>
<tr>
<td>2000–2011</td>
<td>New York City§§</td>
<td>15–64 years</td>
<td>265</td>
<td>10-fold</td>
<td>C, Y</td>
<td></td>
</tr>
<tr>
<td>2011–2013</td>
<td>United Kingdom***</td>
<td>All ages</td>
<td>2,353</td>
<td>5-fold</td>
<td>A, B, C, W, Y</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: ABCs = Active Bacterial Core surveillance; HIV = human immunodeficiency virus.

Use of 9-Valent Human Papillomavirus (HPV) Vaccine: Updated HPV Vaccination Recommendations of the Advisory Committee on Immunization Practices

Ewando Poku-Antwi, MD, DSc; Joseph A. Reusch Jr, MD; Susan Harris, PhD; Harrell Choy, PhD; C. Babette Curtis, MD; Mona Sargent, MD; Elisabeth R. Unger, PhD, MPH; Laura E. Masten, MD (Author affiliations at end of text)

Recommendations for Use of Meningococcal Conjugate Vaccines in HIV-Infected Persons — Advisory Committee on Immunization Practices, 2016

Jessica R. MacNeil, MPH; Lorry G. Ruben, MD; Monica Patton, MD; Imaad R. Ortega-Sanchez, PhD; Stacey W. Martin, MS

MMWR Nov 4, 2016
MMWR Mar 27, 2015
From: Population-Based Incidence Rates of Cervical Intraepithelial Neoplasia in the Human Papillomavirus Vaccine Era

JAMA Oncol. Published online September 29, 2016. doi:10.1001/jamaoncol.2016.3609
STD Screening for MSM

- HIV
- Syphilis
- Urethral GC and CT
- Rectal GC and CT (if RAI)
- Pharyngeal GC (if oral sex)
- HSV-2 serology (consider)
- Hepatitis B (HBsAg, freq not specified)

- Hepatitis C (HIV+ MSM, at least annually)

Anal Cancer in HIV+ MSM: Data insufficient to recommend routine screening, some centers perform anal Pap and HRA

* At least annually, more frequent (3-6 months) if at high risk (multiple/anonymous partners, drug use, high-risk partners) & at relevant anatomic sites

CDC 2015 STD Treatment Guidelines
Serologic Screening for Genital Herpes Infection
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

**IMPORTANCE** Genital herpes is a prevalent sexually transmitted infection in the United States, occurring in almost 1 in 6 persons aged 14 to 49 years. Infection is caused by 2 subtypes of the herpes simplex virus (HSV), HSV-1 and HSV-2. Antiviral medications may provide symptomatic relief from outbreaks but do not cure HSV infection. Neonatal herpes infection, while uncommon, can result in substantial morbidity and mortality.

**OBJECTIVE** To update the 2005 US Preventive Services Task Force (USPSTF) recommendation on screening for genital herpes.

**EVIDENCE REVIEW** The USPSTF reviewed the evidence on the accuracy, benefits, and harms of serologic screening for HSV-2 infection in asymptomatic persons, including those who are pregnant, as well as the effectiveness and harms of preventive medications and behavioral counseling interventions to reduce future symptomatic episodes and transmission to others.

**FINDINGS** Based on the natural history of HSV infection, its epidemiology, and the available evidence on the accuracy of serologic screening tests, the USPSTF concluded that the harms outweigh the benefits of serologic screening for genital HSV infection in asymptomatic adolescents and adults, including those who are pregnant.

**CONCLUSIONS AND RECOMMENDATION** The USPSTF recommends against routine serologic screening for genital HSV infection in asymptomatic adolescents and adults, including those who are pregnant. (D recommendation)


Author/Group Information: The US Preventive Services Task Force (USPSTF) members are listed at the end of this article.

Corresponding Author: Kirsten Bibbins-Domingo, PhD, MD, MAS (chair@uspstf.net).
High proportion of Extragenital CT/GC associated with negative urine test, STD Surveillance Network (n=21,994)

Patton et al CID 2014
UW PTC STI Self-Testing Program
Take-Home Messages

► Screen, appropriately!

► Rescreen for chlamydial and gonococcal infections 3 to 6 months after initial +

► Be aware of antibiotic-resistant GC

► Syphilis: it’s not going away. Recognize neuroinvasive disease

► Hepatitis C

► Sexual health
  – Vaccinate for HPV
    • Continue Pap screening
  – Prevention messages

Wrap It Up Alaska Condoms