

July-August-September 2011

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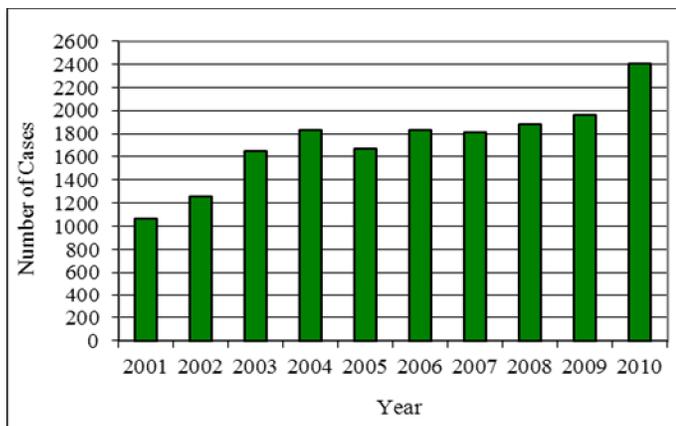
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Sexually Transmitted Disease (STD) 2010 Update

Chlamydia

In 2010, 2,405 cases of chlamydia were reported to the North Dakota Department of Health (NDDoH), a 23 percent increase from the 1,958 cases reported in 2009 (Figure 1). One thousand five hundred seventy-seven (66%) of the cases reported were females. People ages 20 to 24 had the most reported cases with 1,151 (48%) and an increase of 28 percent from the number of cases reported in this age group in 2009. The next highest number of cases were reported among 15- to 19-year-olds with 625 (26%) and 25- to 29-year-olds with 398 (17%) (Figure 2). The increase in chlamydia case reports is likely due to expanded screening efforts.

Figure 1. Reported Chlamydia Cases by Year, North Dakota, 2001-2010



More cases were reported among whites than any other race. Eight hundred forty-seven (35%) cases were reported among whites, followed by American Indians with 393 (16%), African Americans with 108 (4%), Hispanics with 37 (2%), and Asians with 6 (.002%). However, minority populations continue to be disproportionately affected by STDs in North Dakota. The chlamydia rate for African Americans for 2010 was 2,757.2 per 100,000 (Figure 3). Among American Indians, North Dakota's largest minority population, the rate was 1,254.4 per 100,000. In contrast,

the rate among whites in 2010 was 142.8 per 100,000. The rate for all of North Dakota in 2010 was 374.5 per 100,000, compared to 304.9 per 100,000 in 2009.

Figure 2. Reported Chlamydia Cases by Age Group, North Dakota, 2010

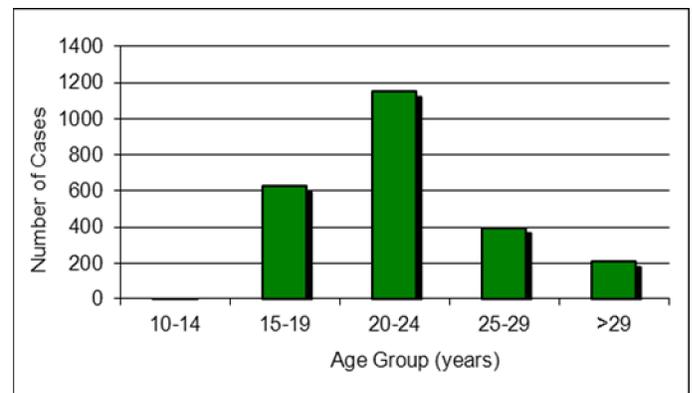
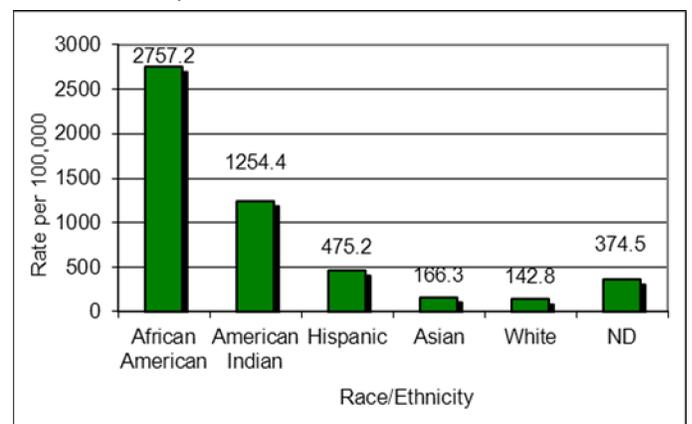


Figure 3. Reported Chlamydia Rates by Race/Ethnicity, North Dakota, 2010



Counties reporting the highest chlamydia rates in North Dakota include Benson, Mountrail, Rolette and Sioux counties with rates of 1,392.9; 965.2; 621.6 and 544.0 per 100,000 population, respectively.

These rates are higher than the rate of 374.5 per 100,000 for all of North Dakota. Several counties noted an increase of chlamydia case reports in 2010 compared to 2009. Reported chlamydia cases in Stutsman County increased 268 percent from 22 cases in 2009 to 81 in 2010. In Williams County, cases increased 85 percent from 40 cases in 2009 to 74 in 2010. In Morton County, cases increased 75 percent from 61 cases in 2009 to 107 in 2010. In Benson County, cases increased 73 percent from 56 cases in 2009 to 97 in 2010. In Stark County, cases increased 39 percent from 52 cases in 2009 to 72 in 2010. Additional county data is located at www.ndhealth.gov/STD/default.htm.

Infertility Prevention and Chlamydia Screening

The Centers for Disease Control and Prevention (CDC) supports a national Infertility Prevention Program (IPP) that funds chlamydia screening and treatment services for low-income, sexually active women attending family planning, STD and other women’s health-care clinics. The primary mission of IPP is to assess and reduce the prevalence of chlamydia and associated complications in family planning and STD clinic populations and other community-based provider populations through outreach, education, screening, treatment and follow-up. North Dakota belongs to the Region VIII IPP, along with South Dakota, Montana, Wyoming, Colorado and Utah. Nine family planning clinics in North Dakota submit data to the Region VIII IPP.

The nine family planning clinics submitted 9,472 specimens for chlamydia testing in 2010, and 821 (8.7%) were positive. Of the family planning specimens, 8,016 were from females and 533 (6.6%) were positive. One thousand four hundred and fifty-six male specimens were submitted and 288 (19.8%) were positive.

In 2010, a total of 21,781 chlamydia tests were performed at the NDDoH’s Division of Laboratory Services, with 1,671 positive results for a positivity rate (percentage of positive test results) of 7.7 percent. In comparison, 20,702 chlamydia tests were performed in 2009, of which 1,398 were reported positive for a positivity rate of 6.8 percent.

Gonorrhea

In 2010, 204 cases of gonorrhea were reported to the NDDoH, a 35 percent increase from the 151 cases reported during 2009 (Figure 4). One hundred and forty (69%) of the cases occurred among females, a 125.8 percent increase compared to 62 female cases for the previous year. The total number of females tested in 2010 increased by 4.6 percent from 16,865 in 2009 to 17,648 in 2010.

Gonorrhea cases among American Indians increased overall in the state by 94.6 percent in 2010 compared to 2009. American Indian females noted a 94.6 percent increase from 37 cases reported in 2009 to 72 reported in 2010.

The number of female American Indians tested in 2010 (2,524) increased by 5.3 percent compared to 2009 (2,396). The increase in the number of American Indian females testing positive may partially be attributed to more females being tested. Furthermore, a cluster of gonorrhea cases occurring in Rolette and Benson Counties also likely contributed to the increase of gonorrhea cases. Rolette County reported 32 cases of gonorrhea in 2010, a 255.6 percent increase compared to nine cases reported in 2009. Benson County noted a 90 percent increase in gonorrhea cases; 19 cases were reported in 2010 compared to 10 cases in 2009.

The age groups that continue to report the highest rates of gonorrhea infections are the 15- to 24-year-olds; accounting for 63.7 percent of gonorrhea cases reported in 2010 (Figure 5).

Figure 4. Reported Gonorrhea Cases by Year, North Dakota, 2001-2010

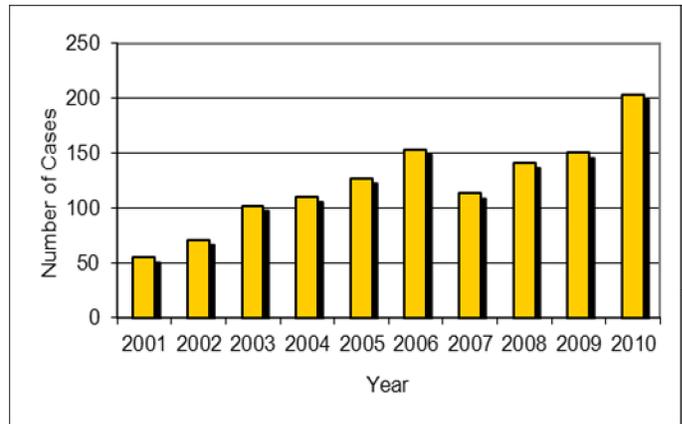
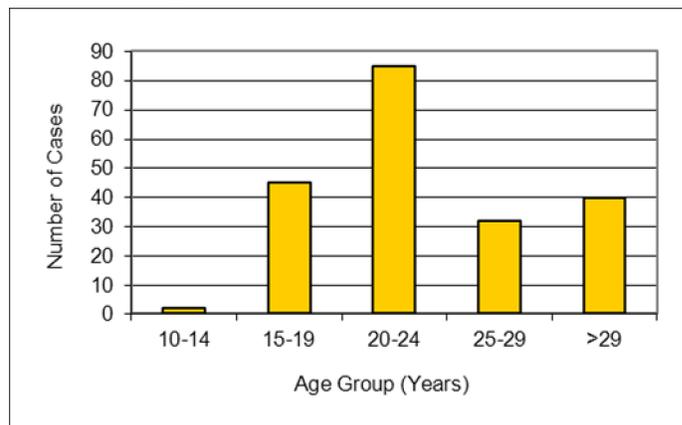


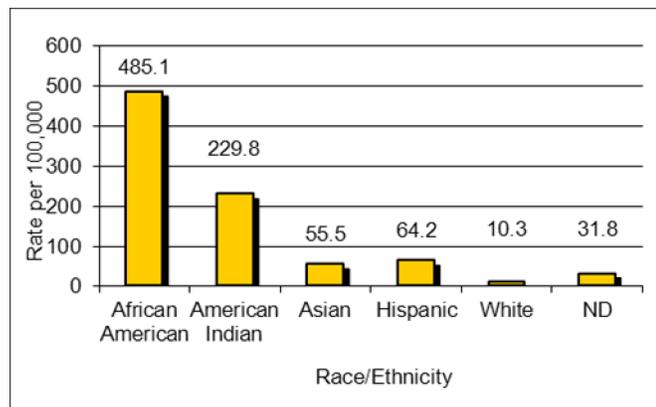
Figure 5. Reported Gonorrhea Cases by Age Group, North Dakota, 2010



The majority of gonorrhea cases were reported among American Indians (72 cases), followed by whites (61 cases) and African Americans (19 cases). Gonorrhea rates continue to reflect disparity among North Dakota racial and ethnic groups.

The gonorrhea rate for African Americans in 2010 was 485.1 per 100,000 and 229.8 per 100,000 for American Indians. In contrast, the rate among whites in 2010 was 10.3 per 100,000 and the rate for all of North Dakota was 31.8 per 100,000 (Figure 6).

Figure 6. Reported Gonorrhea Rates by Race Ethnicity, North Dakota, 2010



In 2010, gonorrhea cases were reported from 18 counties. Benson County reported the highest gonorrhea rate, followed by Rolette and Ramsey Counties with rates of 272.8, 234.0, 74 and 91.2 per 100,000 populations, respectively. These rates are higher than the rate of 31.8 per 100,000 for all of North Dakota. Health-care providers in this region have been notified of the increase of gonorrhea cases. Enhanced surveillance and partner services efforts are underway.

Emerging Antibiotic Resistance Among *Neisseria gonorrhoeae* Isolates

In July 2011, concern about emerging cephalosporin resistance among *Neisseria gonorrhoeae* isolates was published in the Centers for Disease Control and Prevention (CDC) *Morbidity and Mortality Weekly Report* entitled Cephalosporin Susceptibility among *Neisseria gonorrhoeae* Isolates—United States (MMWR 2011; 60 (26) 873-877). This report summarizes an increase in trends of cephalosporin susceptibility among *N. gonorrhoeae* isolates in the United States during 2000 to 2010 using data from the national Gonococcal Isolate Surveillance Project (GISP).

In 2007, the CDC discontinued recommending any fluoroquinolone regimens for the treatment of gonorrhea. CDC now recommends dual therapy for gonorrhea with a cephalosporin (ceftriaxone 250 mg) plus either azithromycin or doxycycline. Emergence of gonococcal resistance to penicillin and tetracycline in the 1970s through the early 1980s, and more recently, fluoroquinolones, has led the CDC to base guidance for the treatment of gonorrhea on surveillance data and trends of elevated minimum inhibitory concentrations (MICs) and

documented treatment failures monitored by the GISP. Although cephalosporins remain an effective treatment for gonococcal infections, health-care providers should be vigilant for treatment failure and are requested to report occurrence of any treatment failures to the North Dakota Department of Health STD Program by calling 800.742.2180.

Syphilis

In 2010, three cases of primary or secondary (P/S) syphilis were reported to the NDDoH, a rate of 0.5 per 100,000 population compared to four cases reported in 2009. Nine P/S syphilis cases were reported between 2006 and 2010: five cases were white, two cases were black, one was Asian/PI and one case’s race remains unknown. Seven cases were male and two female. Two cases were among ages 15-to-19 year olds, three among 20-to-29 year olds, two among 30-to-34 year olds and two cases were older than 45. Of the seven men reported with P/S syphilis between 2006 and 2010, three were MSM, three heterosexual and one whose sexual orientation information is not known. Two heterosexual females were reported with P/S syphilis between 2006 and 2010.

Two early latent syphilis cases were reported between 2006 and 2010: one white and one race unknown. One case was male and one female; ages among 30 to 35 and 15 to 19 years, respectively. Both cases reported their sexual orientation as being heterosexual.

Discordant Results from Reverse Sequence Syphilis Screening

The availability of automatable treponemal enzyme immunoassays (EIA) and chemiluminescence immunoassays (CIA) has led some laboratories to adopt a reverse sequence of screening for syphilis in which a treponemal EIA or CIA is performed first followed by testing of reactive sera with a nontreponemal test, such as the rapid plasma reagin (RPR) test or Venereal Disease Research Laboratory (VDRL) test. In February 2011, the CDC published a *Morbidity and Mortality Weekly Report* entitled Discordant Results from Reverse Sequence Syphilis Screening – Five Laboratories, United States, 2006 to 2010 (February 11, 2011/60(05);133-137). This publication offers guidance to clinicians and public health officials on interpretation of syphilis serology results and appropriate confirmatory testing.

CDC continues to recommend that nontreponemal tests (ex., RPR, VDRL) be used to screen for syphilis and that treponemal testing (ex., FTA-ABS, TP-PA) be used to confirm syphilis. According to CDC, this testing algorithm performs well in identifying individuals with active infection who require further evaluation and treatment and minimizes the occurrence of false-positive results in low prevalence populations.

However, if reverse sequence screening is used, reactive sera by a treponemal test should be tested reflexively with a quantitative nontreponemal test, such as an RPR or VDRL.

When test results are discordant (i.e., reactive EIA/CIA and nonreactive RPR/VDRL), the specimen should be tested reflexively using a confirmatory treponemal test. Patients with discordant serologic results by EIA/CIA and RPR/VDRL testing whose sera are reactive by a confirmatory treponemal test are considered to have past or present syphilis. If the confirmatory treponemal test is nonreactive, syphilis is unlikely. Results from all serologic testing should be reported promptly and concurrently to the clinician and the North Dakota Department of Health.

In addition to serodiagnostic tests, clinicians always should consider the patient's sexual risk factors and medical history, especially history of previous treatment for syphilis. A physical examination also should be performed to assess for evidence of syphilis, especially primary disease (e.g., ulcerative genital or anal lesions).

New 2010 STD Treatment Guidelines are available at www.ndhealth.gov/STD/default.htm.

Key changes include:

- Increased dosage of Ceftriaxone for treatment of gonorrhea infection from 125 mg IM to 250 mg IM in a single dose
- Dual therapy is recommend for treatment of uncomplicated gonorrhea infections *regardless* if chlamydia infection has been ruled out:

Ceftriaxone (250 mg IM in a single dose) or **if not an option** Cefixime (400 mg orally in a single dose) or single-dose injectable cephalosporin regimens

PLUS

Azithromcin (1 g orally in a single dose) or Doxycycline (100 mg orally BID x 7 days)

Expedited Partner Therapy (EPT)

EPT – defined as treatment of partners without an intervening personal assessment by a health-care provider – is an accepted method of treatment of chlamydial infections (ND Administrative Code, Chapter 61-04-04-01).

Visit www.ndhealth.gov/STD/Expedited for more information on EPT including a provider memo, an EPT toolkit and EPT guidance.

Viral Hepatitis Program Update

Activities of the Viral Hepatitis Program include testing at-risk individuals for hepatitis C (HCV); vaccinating at-risk individuals for hepatitis A (HAV); and hepatitis B (HBV); providing educational materials for the general public and for health-care providers; organizing and hosting an HIV/hepatitis conference for health-care Providers; and developing and implementing a statewide media campaign to increase awareness about viral hepatitis.

Currently the NDDoH has contracted with 12 HIV counseling, testing and referral (CTR) sites to implement HCV testing and HBV/HAV vaccination primarily using state funds. CTR sites offering HCV testing and HBV/HAV vaccination are included in Box 1.

Box 1. Hepatitis C Testing Sites, North Dakota

- Bismarck/Burleigh Public Health, Bismarck, N.D.
- Central Valley Health Unit, Jamestown, N.D.
- Custer Health, Mandan, N.D.
- Fargo Cass Public Health, Fargo, N.D.
- First District Health Unit, Minot, N.D.
- Grand Forks Public Health Dept., Grand Forks, N.D.
- Lake Region District Health, Devils Lake, N.D.
- Minne Tohe Health Center, New Town, N.D.
- Richland County Health Dept., Wahpeton, N.D.
- Southwestern District Health Unit, Dickinson, N.D.
- UND Center for Family Medicine, Bismarck, N.D.
- Upper Missouri District Health, Williston, N.D.

Between Jan. 1, 2011, and Sept. 30, 2011, 177 individuals were screened at nine CTR sites and 28 (16%) tested positive, compared to 166 individuals screened at nine CTR sites and 27 (16%) testing positive during the same time period last year. Between Jan. 1, 2011, and May 30, 2011, 1,153 inmates were screened at the North Dakota Department of Corrections and Rehabilitation (NDDOCR), including the state penitentiary and three subsidiary correctional facilities, and 146 (13%) tested positive, compared to the 1,098 inmates screened and 162 (15%) testing positive during the same time period last year.

CTR sites have been receiving and administering HAV/ HBV vaccine since February 2008. Between Jan. 1, 2011, and Sept. 30, 2011, a total of 61 doses were administered at the CTRs, compared to 55 doses administered during the same time period last year. From Jan. 1, 2011, to Sept. 30, 2011, 310 doses were administered at the NDDOCR, compared to 802 doses administered during the same time last year. There were less doses of vaccine administered at the NDDOCR in 2011 due to unavailability of federal funding to purchase vaccine.

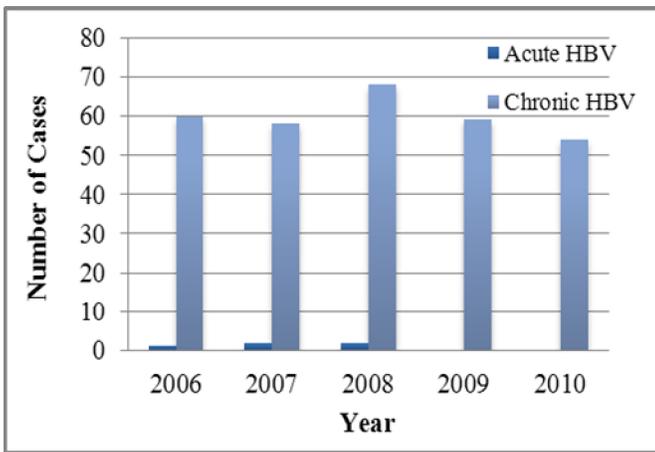
Hepatitis A Virus (HAV)

Historically, North Dakota has had relatively low rates of HAV infection. From 2006 to 2010, 14 cases of acute HAV infection were reported to the NDDoH.

Hepatitis B Virus (HBV)

In 2010, 54 cases of chronic HBV infection and zero cases of acute infection were reported to the NDDoH; an 8.5 percent decrease from the 59 cases reported in 2009 (Figure 7). Morbidity is based on reported positive laboratory results meeting the Centers for Disease Control and Prevention (CDC) case definition of “hepatitis B virus infection, chronic.” Numbers include both confirmed and probable cases.

Figure 7. Reported HBV Cases by Year, North Dakota, 2006-2010.



Of the 54 HBV-positive people reported to the NDDoH, 57 percent were male. Fifty-four percent of reported cases occurred among people between the ages of 18 and 34, and the median age was 32 (range: 12 to 68 years) (Figure 8). Race information was reported for only 26 percent of cases. Among those reporting race, 43 percent were black, 29 percent were white and 14 percent were Asian.

The county in North Dakota that has the highest rate (20.30 per 100,000) of HBV cases is Cass County. The overall rate of HBV in North Dakota is 8.41 per 100,000. Refugee screenings and screenings at medical research account for several HBV infections reported in 2010.

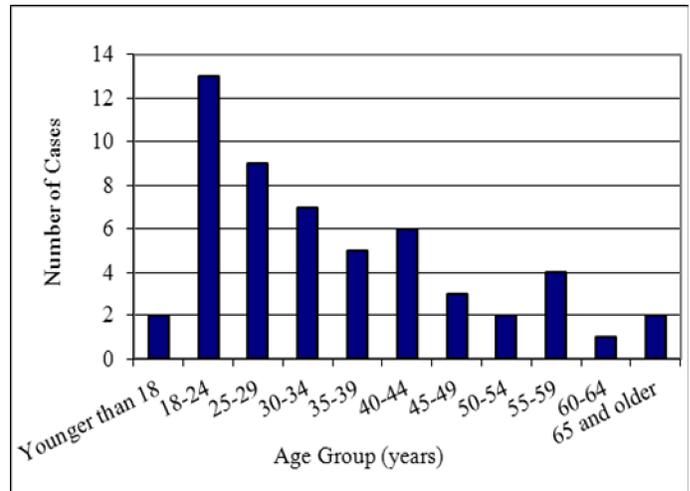
Due to underreporting, asymptomatic or unrecognized HBV infection, the 54 reported infections are likely an underrepresentation of actual disease burden in N.D.

The 2005 [Viral Hepatitis Guide](#) is being updated and will include the following topics:

- Viral Hepatitis Fact Sheets
- HBsAg-Positive Mothers Information
- Viral Hepatitis Markers and Their Significance
- Patient Evaluation for Viral Hepatitis
- Viral Hepatitis Laboratory Test Interpretation
- Postexposure Guidelines for HBV and HCV
- Additional Viral Hepatitis Resources

The Viral Hepatitis Guide will be made available on the NDDoH Viral Hepatitis website.
www.ndhealth.gov/disease/Hepatitis/

Figure 8. Reported HBV Cases by Age Group, North Dakota, 2010



Perinatal Hepatitis B

Perinatal hepatitis B surveillance and reporting are vital to the health of North Dakota infants. Screening all pregnant women for the presence of hepatitis B surface antigen (HBsAg) is a crucial step in controlling and preventing the spread of hepatitis B from mother to infant. However, documented HBsAg-positive mothers often are not screened, especially during later pregnancies, and are therefore not reported to the NDDoH. As a result, many at-risk infants may be missed. Prior to birth, the NDDoH ensures that the delivery hospital has both vaccine and hepatitis B immune globulin (HBIG) on hand, as both should be administered within 12 hours of birth. Infants born to HBsAg-positive mothers are provided both vaccine and HBIG at no charge. In 2008, the NDDoH added pregnancy in women with HBV infection to the mandatory reportable conditions list in order to ensure that all HBV-positive pregnant women are reported to the NDDoH regardless if they were tested during current pregnancy.

Rapid HCV Test Receives CLIA Waiver!

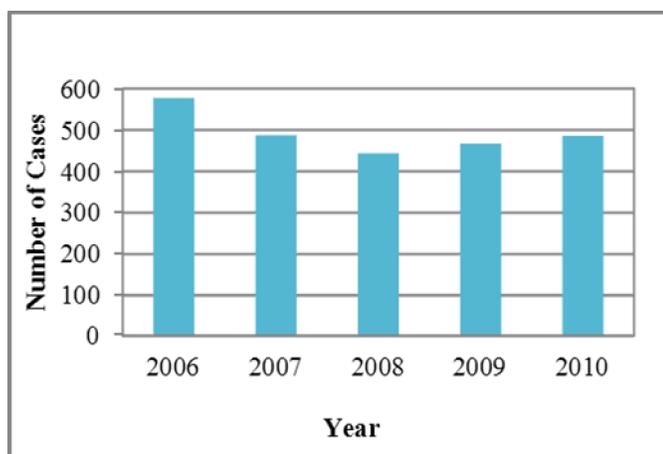
The CLIA (Clinical Laboratory Improvement Amendments) waiver was required to perform this test in point-of-care settings, including CTR sites. Rapid HCV testing will be incorporated into testing sites across N.D. in the future.

Follow-up of HBsAg-positive mothers, infants and other susceptible sexual or household contacts is done to ensure that the infant and contacts receive three doses of the vaccine, that the vaccine is administered appropriately and that the infant receives follow-up testing for hepatitis B antibody levels. Susceptible contacts are screened and offered vaccine at no charge. Between Jan. 1, 2010, and Sept. 30, 2010, seven births to HBsAg-positive pregnant women were reported to the NDDoH; the same number of births were reported during the same time frame last year.

Hepatitis C Virus (HCV)

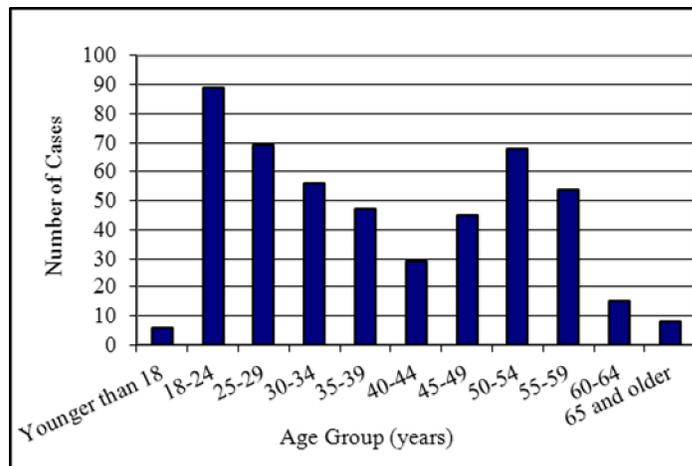
In 2010, the NDDoH received 486 reports of people newly identified as having a positive laboratory result that indicates past or present hepatitis C virus (HCV) infection; a 4.1 percent increase from the 486 cases reported in 2009 (Figure 9). HCV morbidity primarily is based on positive lab results received from laboratories that meet the CDC case definition of “hepatitis C virus infection, past or present.” Numbers do not distinguish between resolved versus active infections.

Figure 9. Reported HCV Cases by Year, North Dakota, 2006-2010



Of the 486 HCV-positive reports, 55 percent were male. Forty-four percent of reported cases occurred among people ages 18 to 39, and the median age was 37 (range: 6 years to 74 years) (Figure 10). In 2010, 89 cases were reported in 18- to 24-year olds; a 70 percent increase from 53 cases in 2009. In 2010, the 18- to 24-year old age group was the most frequently reported age of HCV cases since viral hepatitis surveillance began in 2005. Seventeen percent (15 cases) of the individuals in this age group were inmates of state or local correctional facilities. It is unknown if the increase in cases among this age group are due to increased screening or the increasing number of positive individuals. Race data was available for 29 percent of cases. Among those reporting race, 67 percent were white, 29 percent were American Indian and 1 percent were black.

Figure 10. Reported HCV by Age Group, North Dakota, 2010



The counties in North Dakota with the highest rates of HCV infections include Hettinger, Benson, Rolette, Sioux, Ramsey, Burleigh and Mountrail, reporting the highest incidence rates of 773, 315, 314, 296, 174, 168 and 165 per 100,00 population, respectively. These rates are higher than the rate of 75 per 100,000 for all of North Dakota. The North Dakota State Penitentiary in Bismarck and The Dakota Women’s Correctional and Rehabilitation Center in New England accounted for 84 (17%) HCV cases reported in 2010.

Due to underreporting of cases and asymptomatic or unrecognized HCV infection, the 486 reported cases are likely an underrepresentation of actual disease burden in North Dakota.

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HIV Biannual Update

Table 1 summarizes newly diagnosed HIV/AIDS cases reported from Jan. 1 through June 30, 2011, and compares the data to the same period in 2010. The table also

provides a summary about residents of North Dakota diagnosed with HIV or AIDS and known to be living as of October 31, 2011.

Table 1. New HIV/AIDS Diagnoses and Total HIV/AIDS Cases Living in North Dakota

	New HIV/AIDS cases ¹				Total HIV/AIDS Cases Living in N.D. ²	
	Jan.- June 2010		Jan. - June 2011		Number	Percent*
	Number	Percent*	Number	Percent*		
Diagnosis						
AIDS	1	14%	0	0%	119	50%
HIV	6	86%	3	100%	117	50%
Race/Ethnicity						
American Indian	0	0%	0	0	18	8%
Black	2	29%	0	0	45	19%
Hispanic (all races)	1	14%	0	0	12	5%
Asian/Pacific Islander	0	0%	0	0	2	1%
White	4	57%	3	100%	157	67%
More than one	0	0%	0	0	2	1%
Gender						
Male	5	71%	3	100%	183	78%
Female	2	29%	0	0%	53	22%
Risk						
Heterosexual contact	4	57%	0	0%	38	16%
Injecting drug use (IDU)	0	0%	0	0%	20	8%
Male-to-male sexual contact (MSM)	3	43%	3	100%	109	46%
MSM/IDU	0	0%	0	0%	13	6%
Perinatal transmission	0	0%	0	0%	0	2%
Adult Hemophilia/coagulation disorder	0	0%	0	0%	1	0%
Receipt of blood or tissue	0	0%	0	0%	1	0%
Risk not specified	0	0%	0	0%	54	23%
Age Group						
≤15	0	0%	0	0	6	3%
15-24	2	29%	2	67%	33	14%
25-34	2	29%	1	33%	84	36%
35-44	3	43%	0	0	75	32%
45-54	0	0%	0	0	28	12%
55-64	0	0%	0	0	10	4%
65+	0	0%	0	0	0	0%
Total	7		3		236	

*Due to rounding, totals may not equal 100%.

¹New HIV/AIDS cases reflects HIV cases that were newly diagnosed in North Dakota during the listed time period. These cases include those which are classified as AIDS cases at initial diagnosis.

²Total HIV/AIDS cases living in ND reflect HIV/AIDS cases which were alive and residing in North Dakota as of October 31, 2011.

Cumulative HIV/AIDS Reported Cases

Cumulative reported cases include newly diagnosed cases of HIV infection and AIDS in North Dakota residents and cases previously diagnosed in other states who resided in North Dakota during the reporting period.

As of October 31, 2011, 520 cumulative HIV/AIDS cases have been reported to the North Dakota Department of Health (NDDoH) since HIV/AIDS surveillance began in 1984. Of these, 236 are known still to be living in North Dakota.

Most frequently reported risk factors are unprotected male-to-male sexual contact (50%), unprotected heterosexual contact (14%) and injecting drug use (8%).

Of the 520 reported cases:

- 83 percent are male; 17 percent are female.
- 65 percent were between the ages of 25 and 44 at time of diagnosis.
- 73 percent (378) are white; 9 percent (49) are American Indian; 13 percent (67) are black; 4 percent (19) are Hispanic – any race; and less than 1 percent are Asian/Pacific Islander.

All HIV/AIDS data are based on the best information Available, but are subject to change as more complete information is received. Please note that a slight change in the number of reported HIV cases will result in significant changes in rates because of the relatively low populations in the denomination.

Reporting HIV/AIDS Diagnoses

North Dakota health-care and service providers are required to report to the NDDoH anyone with HIV for whom they are providing care or services.

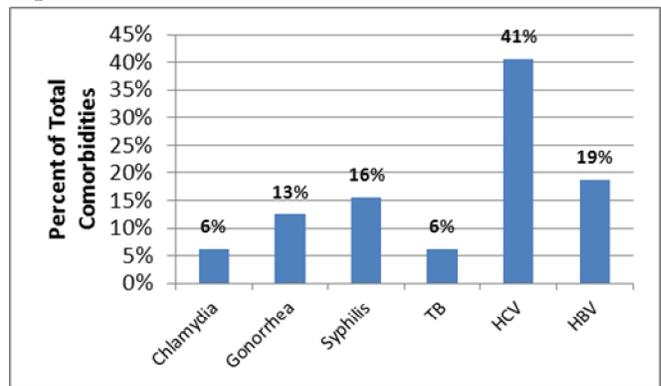
The following indicators of HIV infection are mandated as reportable to the NDDoH: a confirmed positive HIV antibody screen, detectable and non-detectable viral load test results, and any CD4 T-lymphocyte test result.

Accurately counting newly diagnosed HIV and AIDS cases can impact federal resources allocated to North Dakota for HIV/AIDS prevention, care and supportive services and surveillance activities.

Hepatitis B, Hepatitis C, STD, TB and HIV/AIDS Co Infection

An estimated one-quarter of HIV-infected people in the U.S. also are infected with HCV. HIV-infected injection drug users are commonly (50% to 90%) coinfecting with HCV. HCV causes a rapid progression to liver damage in an HIV-infected person. Hepatitis B also is a common coinfection with HIV since transmission is primarily through sexual contact and injection drug use. As with HCV, people who are coinfecting with HIV and HBV have an increased risk for liver-related morbidity and mortality.

Figure 11. Percentage of HIV Cases with Comorbidities Reported, 2006-2010



An HIV-infected individual who also is infected with another STD is more likely to transmit HIV through sexual contact than other HIV-infected people. Coinfection of HIV and STDs increases the concentration of HIV in genital secretions, causing increased infectiousness. If exposed to HIV infection through sexual contact, individuals who are infected with STDs are at least two to five times more likely than uninfected individuals to acquire HIV infection.

Figure 11 demonstrates that the most common comorbidity in North Dakota is HIV and hepatitis C. It is very important to know the health implications and risk behaviors associated with coinfections. Table 2 demonstrates the risk factors of HIV/AIDS cases with coinfections in North Dakota in order to provide appropriate medical management for these cases.

Table 2. Risk Factors of HIV/AIDS Cases with Comorbidities 2006 - 2010

Risk Factors	Co Morbidities					
	Chlamydia	Gonorrhea	Syphilis	TB	HCV	HBV
Male-to-male sexual contact (MSM)	0	3	4	1	2	1
Injecting drug use (IDU)	0	0	0	0	2	0
MSM/IDU	0	0	0	0	2	1
Heterosexual contact	2	1	1	1	4	3
Hemophilia/coagulation disorder	0	0	0	0	1	0
Risk not specified	0	0	0	0	2	1

Summary of Selected Reportable Conditions					
North Dakota, 2010-2011					
Reportable Condition	July-Sept. 2011*	January-Sept. 2011*		July-Sept. 2010	January-Sept. 2010
Campylobacteriosis	45	113		35	89
Chickenpox	8	31		4	34
Chlamydia	624	1740		665	1771
Cryptosporidiosis	9	29		12	29
E. coli, shiga toxin positive (non-O157)	3	13		4	10
E. coli O157:H7	2	4		5	7
Enterococcus, Vancomycin-resistant (VRE)	23	157		97	274
Giardiasis	16	46		15	27
Gonorrhea	62	174		60	154
Haemophilus influenzae (invasive)	1	11		2	10
Acute Hepatitis A	1	1		0	2
Acute Hepatitis B	0	0		0	0
Acute Hepatitis C	0	0		0	0
HIV/AIDS ¹	5	19		8	22
Influenza	4	46		2	30
Legionellosis	0	1		1	4
Listeria	1	2		1	1
Lyme Disease	14	22		22	30
Malaria	0	0		0	0
Meningococcal disease ²	0	1		1	2
Mumps	1	6		0	1
Pertussis	5	37		27	49
Q fever	0	0		1	1
Rabies (animal)	4	11		10	16
Rocky Mountain spotted fever	0	2		0	1
Salmonellosis	18	46		30	48
Shigellosis	1	1		0	0
Staphylococcus aureus, Methicillin-resistant (MRSA)	18	61		17	34
Streptococcal pneumoniae ³ , (invasive, children < 5 years of age)	0	1		0	1
Syphilis, Primary and Secondary	0	0		0	0
Trichinosis	0	0		0	0
Tuberculosis	1	8		0	7
Tularemia	1	1		1	1
Typhoid fever	0	0		0	1
West Nile Virus Infection	4	4		8	9

*Provisional data

¹ Includes newly diagnosed cases and cases diagnosed previously in other states that moved to North Dakota.

² Includes confirmed, probable and suspect meningococcal meningitis cases.

³ Includes invasive infections caused by streptococcal disease not including those classified as meningitis.