

July-August-September 2012

In this Issue:

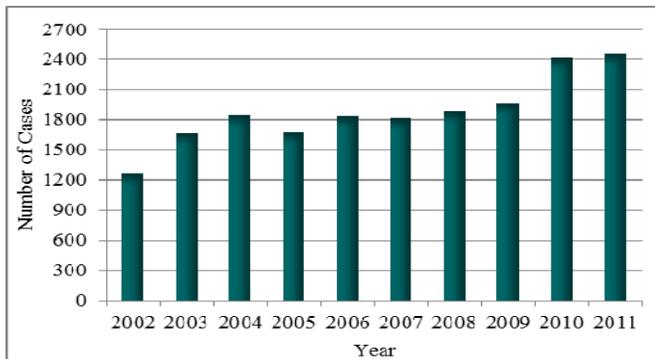
- ◆ STD 2011 Update
- ◆ Viral Hepatitis Program Update
- ◆ HIV Biannual Update
- ◆ Summary of Selected Reportable Conditions

Sexually Transmitted Disease (STD) 2011 Update

Chlamydia

In 2011, 2,450 cases of Chlamydia were reported to the North Dakota Department of Health (NDDoH), a 1.9 percent increase from the 2,405 cases reported in 2010 (**Figure 1**). Of the cases reported, 1,605 (66%) were females. People ages 20 to 24 had the most reported cases with 1,149 (47%). The next highest number of cases were reported among 15- to 19-year-olds with 656 (27%) and 25- to 29-year-olds with 388 (16%) (**Figure 2**).

Figure 1. Reported Chlamydia Cases by Year, North Dakota, 2002-2011



In 2011, 32 percent of chlamydia cases were reported with an unknown race. Of cases with known race, 1,107 (66%) cases were reported among whites followed by American Indians with 408 (24%), African Americans with 122 (7%), Hispanics with 26 (2%), and Asians with 12 (1%). Although there was a 31 percent increase in the number of cases reported among whites in 2011 (1,107 cases in 2011 compared to 847 cases in 2010), minority populations continue to be disproportionately affected by STDs in North Dakota. The chlamydia rate for African Americans for 2011 was 3,114.6 per 100,000 (**Figure 3**). Among American Indians, North Dakota's largest minority population, the rate was 1,302.3 per 100,000. In contrast, the rate among whites in 2011 was 186.6 per 100,000.

The rate for all of North Dakota in 2011 was 381.5 per 100,000, compared to 374.5 per 100,000 in 2010.

Figure 2. Reported Chlamydia Cases by Age Group, North Dakota, 2011

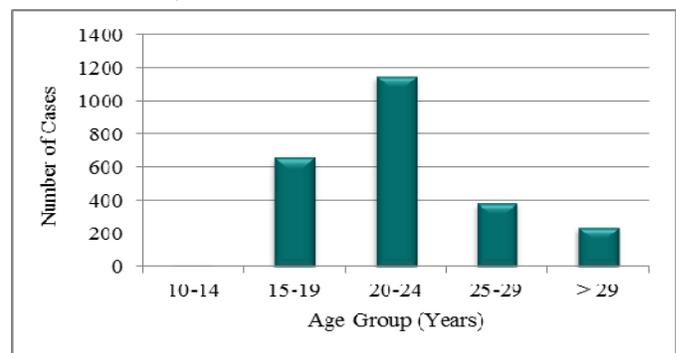
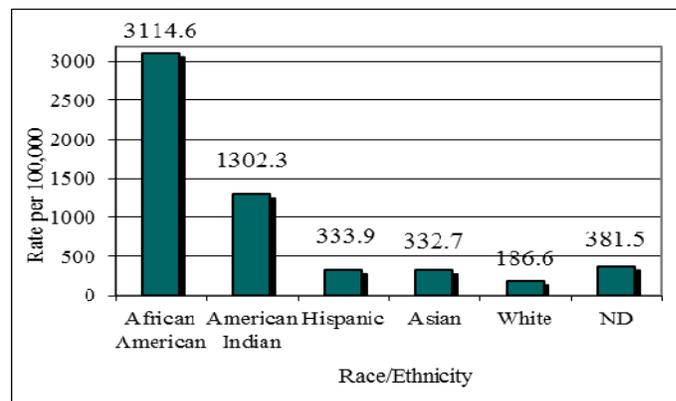


Figure 3. Reported Chlamydia Rates by Race/Ethnicity, North Dakota, 2011



Counties most often reporting the highest chlamydia rates in North Dakota are those where American Indian reservations are located: Benson, Sioux, Mountrail and Rolette counties reported the highest incidence rates of 1,216; 1,107; 821; and 621 per 100,000 population, respectively. These rates are higher than the rate of 364 per 100,000 for all of North Dakota.

The number of reported chlamydia cases in McKenzie County increased 110 percent from 10 cases in 2010 to 21 in 2011; in Sioux County cases increased 109 percent from 22 cases in 2010 to 46 in 2011; and in Williams County cases increased 66 percent from 74 cases in 2010 to 123 in 2011.

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.

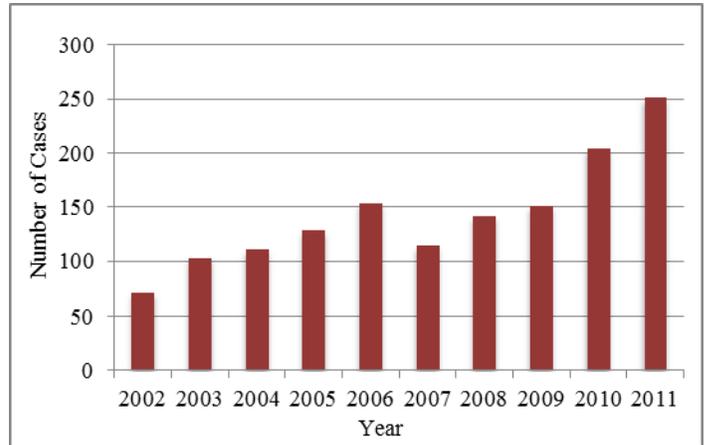
The nine family planning clinics submitted 8,829 specimens for chlamydia testing in 2011, and 716 (8.1%) were positive. In 2011, 7,356 specimens were from females and 463 (6.3%) were positive. Of the specimens submitted from males, 1,473 (17.2%) were positive.

In 2011, a total of 20,805 chlamydia tests were performed at the NDDoH’s Division of Laboratory Services, with 1,610 positive results (7.7 %). In comparison, 21,781 chlamydia tests were performed in 2010, of which 1,671 were reported positive (7.7%).

Gonorrhea

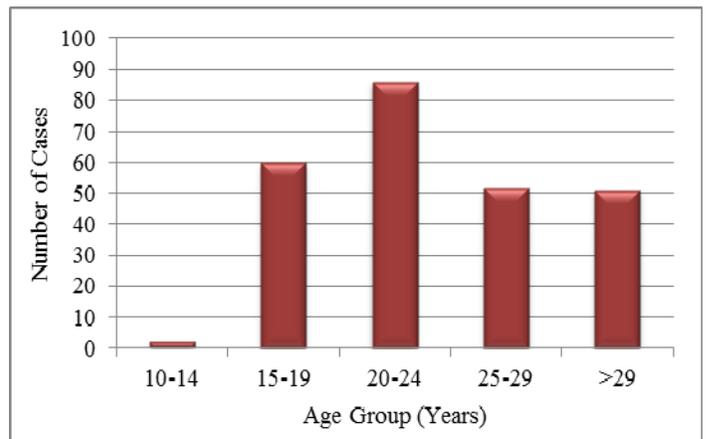
In 2011, 251 cases of gonorrhea were reported to the NDDoH, a 23 percent increase from the 204 cases reported during 2010 (**Figure 4**). Of the cases, 149 (59%) occurred among females and 101 cases occurred among males. An increase in males testing positive at Indian Health Services facilities in Sioux County, Benson County and Mountrail County account for the majority of the increase of gonorrhea cases among males in 2011. Although there was an increase of cases among males in these counties, there was not an increase in the number of males being tested, which could reflect an increase in successful partner services in these areas or could reflect an increase in disease prevalence.

Figure 4. Reported Gonorrhea Cases by Year, North Dakota, 2002-2011



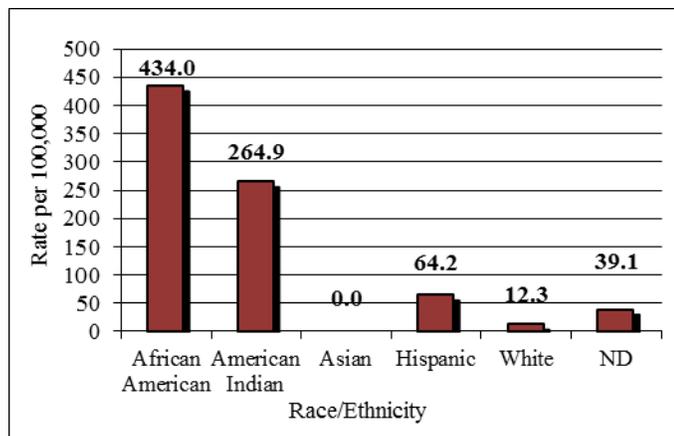
The age groups that continue to report the highest number of cases of gonorrhea infections continue to be among 15- to 24-year-olds; accounting for 58.2 percent of gonorrhea cases reported in 2011 (**Figure 5**). The number of cases among 25- to 29-year olds in 2011 was 52, an increase of 62.5 percent compared to the 32 cases reported in 2010.

Figure 5. Reported Gonorrhea Cases by Age Group, North Dakota, 2011



The majority of gonorrhea cases were reported among American Indians (83 cases), followed by whites (73 cases) and African Americans (17 cases). Thirty-one percent of gonorrhea cases were reported with unknown race. Gonorrhea rates continue to reflect disparity among North Dakota racial and ethnic groups. The gonorrhea rate for African Americans in 2011 was 434.0 per 100,000, and 264.9 per 100,000 for American Indians. In contrast, the rate among whites in 2011 was 12.3 per 100,000, and the rate for all of North Dakota was 39.1 per 100,000 (**Figure 6**).

Figure 6. Reported Gonorrhea Rates by Race Ethnicity, North Dakota, 2011



In 2011, gonorrhea cases were reported from 26 counties compared to 18 counties in 2012. Sioux County reported the highest gonorrhea rate, followed by Benson, Billings and Rolette counties with rates of 457, 180, 127 and 114 per 100,000 populations, respectively. These rates are higher than the rate of 37.3 per 100,000 for all of North Dakota. Sioux County had an 850 percent increase in cases in 2011 with 19 cases, compared to two cases being reported in 2010.

Updated Gonorrhea Treatment Recommendations and Expedited Partner Therapy

In response to recent surveillance data, the CDC released new recommendations for the treatment of gonorrhea. The recommendations were published in the MMWR “Update to CDC’s Sexually Transmitted Diseases Treatment Guidelines, 2010: Oral Cephalosporins No Longer a Recommended Treatment for Gonococcal Infections” released on August 10, 2012, available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6131a3.htm.

In 2007, due to widespread drug resistance, CDC revised its gonorrhea treatment guidelines to no longer recommend fluoroquinolones. Cephalosporins, including the oral antibiotic cefixime and the injectable antibiotic ceftriaxone became the only treatment available to effectively treat gonorrhea. Evidence from CDC’s Gonococcal Isolate Surveillance Project (www.cdc.gov/std/gisp/) suggests that cefixime is becoming less effective in treating gonorrhea. Although no patients have failed treatment with cefixime in the United States, a small number of patients have experienced cefixime treatment failures in other countries. Due to latest U.S. surveillance data and the past experience with resistance strains spreading, it is only a matter of time before gonorrhea becomes resistant to the only remaining currently available treatments. The possibility of widespread resistance prompted updated gonorrhea treatment guidelines.

Per the updated treatment guidelines:

- Cefixime is no longer a recommended treatment for gonorrhea. It is listed as an alternative treatment if an injection is not an option.
- The recommended treatment of gonorrhea is ceftriaxone 250 mg IM in a single dose along with either azithromycin 1 g orally or doxycycline 100 mg BID x 7 days.
- Cefixime has limited efficacy for treating gonococcal infections of the pharynx. If oral sex is reported, patients and partners should be treated with ceftriaxone.
- Although cefixime is no longer a recommended treatment for gonorrhea, it can still be used for expedited partner therapy (EPT). EPT should be used as a last resort for treating heterosexual partners of gonorrhea cases. EPT is not recommended for men who have sex with men for either chlamydia or gonorrhea.

CDC is encouraging providers to monitor for suspected ceftriaxone treatment failures. According to the new guidelines, patients who have persistent symptoms should be retested with a culture-based gonorrhea test, which can identify antibiotic-resistant infections. The patient should return one week after re-treatment for another culture test to ensure the infection is fully cured. Suspected treatment failures should be reported to the North Dakota Department of Health.

If you have any questions about gonorrhea treatment or expedited partner therapy, call 800.472.2180 or visit www.ndhealth.gov/STD/default.htm.

Syphilis

In 2011, two cases of primary or secondary (P/S) syphilis were reported to the NDDoH, a rate of 0.3 per 100,000 population compared to three cases reported in 2010. Ten P/S syphilis cases were reported between 2007 and 2011. Both cases were reported among males in 2011. One case was heterosexual, used non-injection drugs, had anonymous sex partners and was also co-infected with HIV. The second case was MSM who had anonymous sex partners. Their ages were in the range of 30 to 45 years of age.

Six additional cases of syphilis were reported to the NDDoH in 2011. Three cases were diagnosed as latent syphilis of unknown duration, one was early latent and two cases were diagnosed with neurosyphilis. Five (83%) were reported among males. Ages ranged from 20 to 63 with a median of 37 years. Of these six cases, three were also HIV positive. One case was also infected with gonorrhea and chlamydia. Three cases were reported to be MSM. Risk factors reported among these cases included anonymous sex partners and drug use.

Discordant Results from Reverse Sequence Syphilis Screening

The availability of automated 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, 2006-2010* (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 (e.g., RPR, VDRL) be used to screen for syphilis and that treponemal testing (e.g., FTS-ABS, TPPA) 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 state health department.

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).

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)/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, developing and implementing a statewide media campaign to increase awareness about viral hepatitis; and contracting with local public health units (LPHUs) to provide the above-

mentioned viral hepatitis services. Currently the NDDoH has contracted with 13 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
Central Valley Health Unit
Custer Family Planning
Custer Health
Fargo Cass Public Health
First District Health Unit
Grand Forks Public Health Dept.
Lake Region District Health
Minne Tohe Health Center
Richland County Health Dept.
Southwestern District Health Unit
UND Center for Family Medicine - Bismarck
Upper Missouri District Health

Between Jan. 1, 2012, and Sept. 30, 2012, 259 individuals were screened at nine CTR sites and 28 (11%) tested positive, compared to 177 individuals screened at nine CTR sites and 28 (16%) testing positive during the same time period last year. Between Jan. 1, 2012, and September 30, 2012, 939 inmates were screened at the North Dakota Department of Corrections and Rehabilitation (NDDOCR), including the state penitentiary and three subsidiary correctional facilities, and 158 (17%) tested positive, compared to the 875 inmates screened and 146 (17%) 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, 2012, and Sept. 30, 2012, a total of 105 doses were administered at the CTRs, compared to 61 doses administered during the same time period in 2011.

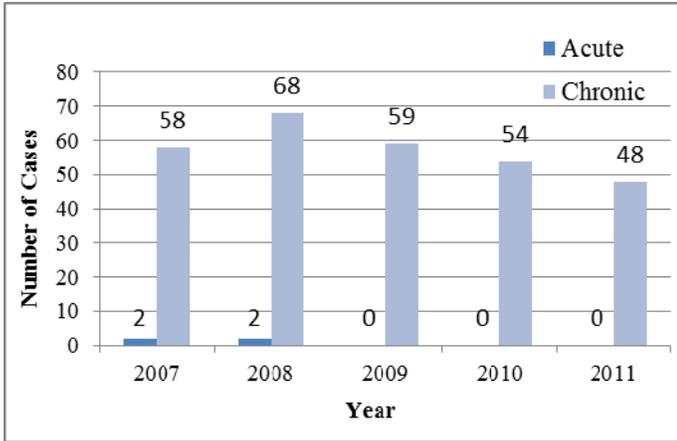
Hepatitis A Virus (HAV)

Historically, North Dakota has had relatively low rates of HAV infection. From 2007 to 2011, 10 cases of acute HAV infection were reported to the NDDoH.

Hepatitis B Virus (HBV)

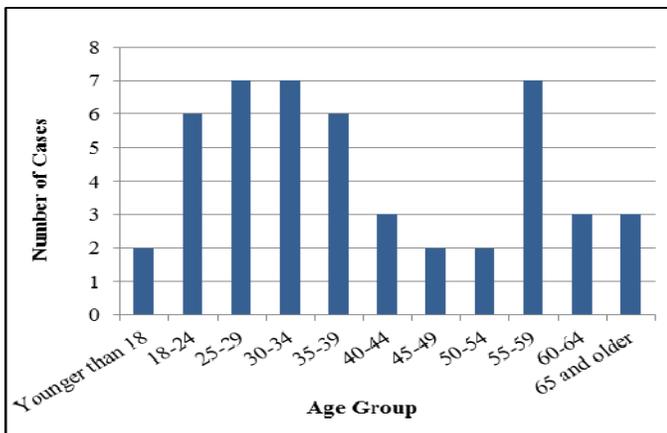
In 2011, 48 cases of chronic HBV infection and no cases of acute infection were reported to the NDDoH, an 11 percent decrease from the 54 cases reported in 2010 (**Figure 7**). Morbidity is based on reported positive laboratory results meeting the Centers for Disease Control and Prevention (CDC) case definition of "hepatitis B virus infection, chronic." Numbers include both confirmed and probable cases.

Figure 7. Reported HBV Cases by Year, North Dakota, 2007-2011.



Of the 48 HBV-positive people reported to the NDDoH, 56 percent were male. Fifty-four percent of reported cases occurred among people between the ages of 18 and 39, and the median age was 36 (range: 9 to 77 years) (Figure 8). Race information was reported for only 29 percent of cases. Among those reporting race, 43 percent were black, 43 percent were white, seven percent were Asian and seven percent were American Indian.

Figure 8. Reported HBV Cases by Age Group, North Dakota, 2011



The county in North Dakota that has the highest rate (15.02 per 100,000) of HBV cases is Benson County followed by Cass County with a rate of 14.69 per 100,000 population. The overall rate of HBV in North Dakota is 7.14 per 100,000. Refugee screenings and screenings for medical research or blood or plasma donation account for several HBV infections reported in 2011.

Due to underreporting, asymptomatic or unrecognized HBV infection, the 48 reported infections are likely an underrepresentation of actual disease burden in North Dakota.

Perinatal Hepatitis B

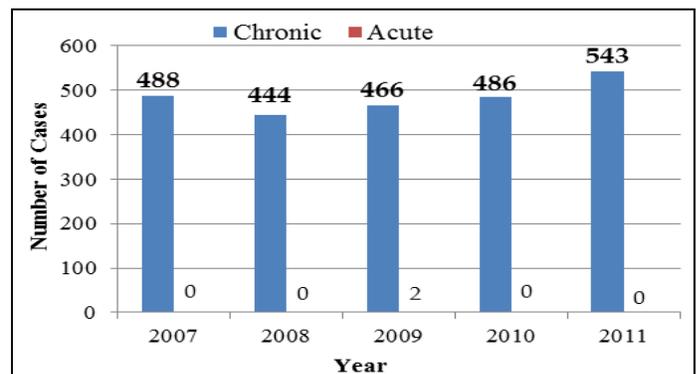
Perinatal hepatitis B surveillance and reporting are vital to the health of North Dakota infants. Screening all pregnant women for the presence of hepatitis B surface antigen (HBsAg) is a crucial step in controlling and preventing the spread of hepatitis B from mother to infant. However, documented HBsAg-positive 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 North Dakota Department of Health 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.

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, 2012, and Sept. 30, 2012, seven births to HBsAg-positive pregnant women were reported to the NDDoH; 15 births were reported during the same time frame last year.

Hepatitis C Virus (HCV)

In 2011, the NDDoH received 543 reports of people newly identified as having a positive laboratory result that indicates past or present hepatitis C virus (HCV) infection, a 11.7 percent increase from the 486 cases reported in 2010 (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, 2007-2011



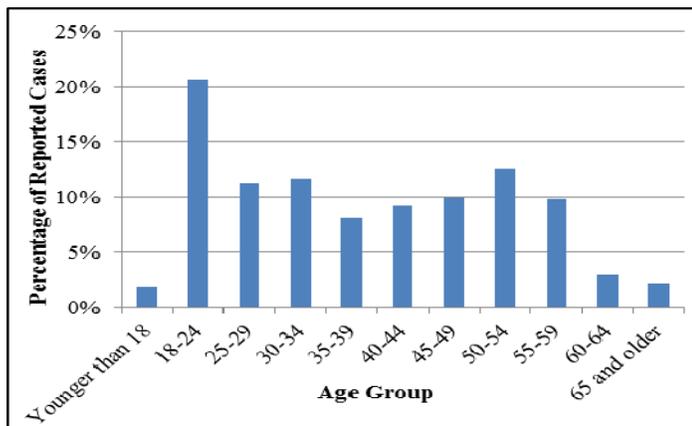


What's New!!

Of the 543 HCV-positive reports, 56 percent were male. Since 2007, more than 53 percent of reported hepatitis C cases occurred in those 40 years and older. However, the percentage of cases being reported from age 18 to 24 has been increasing since 2009. As in 2010, the most frequently reported age in 2011 was 18-to 24-year olds (**Figure 10**). In 2011, 112 cases were reported in this age group, a 60 percent

increase since 2010 and a 111.3 percent increase since 2009. Seventeen percent (19 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 rates or increasing number of positive individuals. Also, it is not known whether the increases are resulting from efforts of public or private health-care providers across the state or in specific regions of North Dakota. Race data was available for 29 percent of cases. Among those reporting race, 60 percent were white and 36 percent were American Indian.

Figure 10. Reported HCV by Age Group, North



Dakota, 2011

The counties in North Dakota with the highest rates of HCV infections are those with facilities from the North Dakota Department of Corrections and where American Indian reservations are located: Benson, Hettinger, Mountrail, Rolette, Sioux and Towner reported the highest incidence rates of 480, 807, 391, 165, 240 and 222 per 100,000 population, respectively. These rates are higher than the rate of 80.7 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 81 (15%) HCV cases reported in 2011 compared to 17 percent of HCV cases reported in 2010.

Due to underreporting of cases and asymptomatic or unrecognized HCV infection, the 543 reported cases are likely an underrepresentation of actual disease burden in North Dakota.

Rapid Hepatitis C Testing

The U.S. Food and Drug Administration (FDA) announced approval of the **first rapid test** for antibodies to the **hepatitis C virus** for individuals 15 and older.

- Results are available in 20 minutes.
- Rapid HIV and HCV tests can be conducted simultaneously.
- Rapid HCV testing will be available at CTR sites in 2012.
- The ND Board of Clinical Laboratory Practice is in the process of granting exemption for the OraQuick HCV rapid test and shall be completed by summer 2012. Until then, nurses, lab technicians and other qualified health professionals can utilize this rapid test in clinic and outreach settings.

HIV/STD/TB/Hepatitis Programs

In June 2012, the STD and hepatitis programs merged with the HIV/TB programs to form one large program.

Listed below is contact information and overview of the staff and responsibilities of this program.

Program Manager:

Lindsey VanderBusch

701-328-4

STD/HCV Program Coordinator:

Sarah Weninger

701.328.2366 ~ sweninger@nd.gov

HIV/AIDS Surveillance Program

Coordinator/TB Controller:

Dee Pritschet

701.328.2377 ~ djpritschet@nd.gov

HIV Prevention Program Coordinator:

Shannon Jahner

701.328.1059 ~ sjjahner@nd.gov

Ryan White Coordinator:

Gordana Cokrlic

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HIV Biannual Update

Table 1 summarizes newly diagnosed HIV/AIDS cases reported from Jan. 1 through June 30, 2012, and compares the data to the same period in 2011.

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, 2012.

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 2011		Jan. - June 2012		Number	Percent*
	Number	Percent*	Number	Percent*		
Diagnosis						
AIDS	0	0%	1	20%	141	50%
HIV	3	100%	4	80%	144	50%
Race/Ethnicity						
American Indian	0	0%	0	0%	20	8%
Black	0	0%	3	60%	59	19%
Hispanic (all races)	0	0%	0	0%	12	5%
Asian/Pacific Islander	0	0%	0	0%	2	1%
White	3	100%	2	40%	190	67%
More than one	0	0%	0	0%	2	1%
Gender						
Male	3	100%	2	40%	218	78%
Female	0	0%	3	60%	67	22%
Risk						
Heterosexual contact	0	0%	4	80%	100	35%
Injecting drug use (IDU)	0	0%	0	0%	21	7%
Male-to-male sexual contact (MSM)	3	100%	1	20%	130	46%
MSM/IDU	0	0%	0	0%	16	6%
Perinatal transmission	0	0%	0	0%	5	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%	11	4%
Age Group						
≤15	0	0%	0	0%	8	3%
15-24	2	67%	1	20%	45	16%
25-34	1	33%	0	0%	101	35%
35-44	0	0%	2	40%	89	31%
45-54	0	0%	1	20%	29	10%
55-64	0	0%	1	20%	13	5%
65+	0	0%	0	0%	0	0%
Total	3		5		285	

*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, 2012.

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, 2012, 578 cumulative HIV/AIDS cases have been reported to the North Dakota Department of Health (NDDoH) since HIV/AIDS surveillance began in 1984. Of these, 285 are known still to be living in North Dakota.

Most frequently reported risk factors are unprotected male-to-male sexual contact (51%), unprotected heterosexual contact (16%) and injecting drug use (11%).

Of the 578 reported cases:

- 82 percent are male; 18 percent are female.
- 66 percent were between the ages of 25 and 44 at time of diagnosis.
- 73 percent (420) are white; 9 percent (53) are American Indian; 14 percent (81) are black; 3 percent (20) 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.

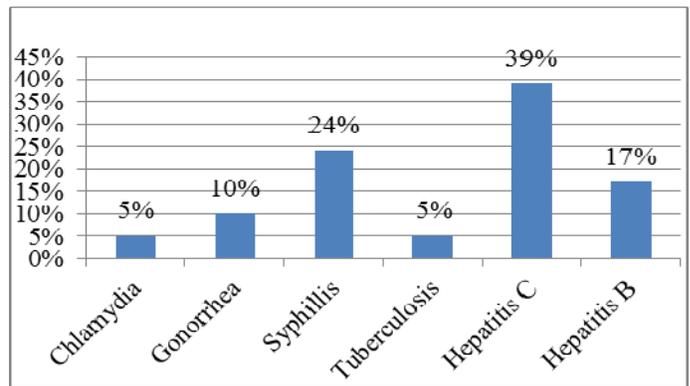
The following indicators of HIV infection are mandated as reportable to the NDDoH: a confirmed positive HIV antibody screen, detectable and non-detectable viral load test results, and any CD4 T-lymphocyte test result.

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, 2006-2011



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.

Risk Factors	Co Morbidities					
	Chlamydia	Gonorrhea	Syphilis	TB	HCV	HBV
Male-to-male sexual contact (MSM)	0	3	7	1	3	2
Injecting drug use (IDU)	0	0	0	0	2	0
MSM/IDU	0	0	2	0	3	1
Heterosexual contact	2	1	1	1	5	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, 2011-2012					
Reportable Condition	July-Sept. 2012*	January-Sept. 2012*		July-Sept. 2011	January-Sept. 2011
Campylobacteriosis	34	85		43	110
Chickenpox	7	16		10	30
Chlamydia	806	2198		644	1830
Cryptosporidiosis	11	30		9	28
E. coli, shiga toxin positive (non-O157)	8	11		3	6
E. coli O157:H7	7	8		2	4
Enterococcus, Vancomycin-resistant (VRE)	107	365		94	325
Giardiasis	30	48		16	46
Gonorrhea	88	224		64	185
Haemophilus influenzae (invasive)	4	13		3	12
Acute Hepatitis A	1	2		0	0
Acute Hepatitis B	0	0		0	0
Acute Hepatitis C	0	0		0	0
HIV/AIDS ¹	13	33		8	22
Influenza	3	1476		4	2037
Legionellosis	0	0		1	2
Listeria	0	0		1	2
Lyme Disease	5	9		17	26
Malaria	1	1		0	0
Meningococcal disease ²	1	1		0	0
Mumps	0	1		1	6
Pertussis	90	170		14	47
Q fever	0	0		0	0
Rabies (animal)	4	29		6	15
Rocky Mountain spotted fever	0	1		0	2
Salmonellosis	24	49		18	46
Shigellosis	4	6		1	1
Staphylococcus aureus, Methicillin-resistant (MRSA)	32	85		21	63
Streptococcal pneumoniae ³ , (invasive, children < 5 years of age)	0	1		2	3
Syphilis, Primary and Secondary	1	3		0	0
Trichinosis	0	0		0	0
Tuberculosis	7	14		0	5
Tularemia	2	3		1	2
Typhoid fever	0	0		0	0
West Nile Virus Infection	88	88		4	4

*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.