EL PASO COUNTY HEALTH DEPARTMENT

501 North Foote Avenue

Colorado Springs, Colorado. 80909-4598

ANNUAL REPORT

Venereal Disease Program

January 1, 1984 - December 31, 1984

1984 Prevalence = ~~Incidence~~ Importation X Duration

PART ONE
GONORRHEA

Overview

For calendar year 1984 we report 1525 gonorrhea cases, a virtual 20 percent increase over 1983 (1280 cases). This notable increase occurred in context of declining State(-2 percent exclusive of El Paso County in 1984) and national (-7 percent) gonorrhea incidence. To add insult to peculiarity, the rate of increase was much steeper than observed during the "great epidemic", when rates of increase ranged from 8 to 16 percent and averaged about 12 percent annually for a decade (1966-1975). That the 1984 increase should have unfolded despite the best control efforts ever applied in El Paso County adds the ironic touch.

The increase was due to importation. Of that, there is little doubt. The remainder of Part One supplies data to support our assertion. Part Two deals with sexually transmitted diseases other than gonorrhea and with miscellaneous Program data. Part Three consists of Appendices and tabular data.

I. Temporal distribution

Most of the 245 "excess" gonorrhea cases noted in 1984 can be attributed to two waves of importation: the first hit subsequent to the return of our troops from Honduras in February; the second splashed mid-summer.

The story of the Honduras-derived outbreak was nicely summarized in a memorandum dated 5 April '84 (Appendix A) and need not be recapitulated. The prolonged sojourn (circa 6 months) of our troops in Central America was the crucial factor: their sexual partners in the United States acquired gonorrhea during their absence and conferred infection upon the troops after their return. (Military maneuvers of shorter duration have not, in the past, generated substantial numbers of excess cases. Annual REFORGER (REinforcement FORces GERmany) deployment and desert-setting exercises (California) seldom last more than forty days. Simply put: the soldiers in the field have few sexual opportunities and, more importantly, their sexual partners at home have more patience with short-term abstinence.) In a sense, it is fortunate that the troops returned in early February, traditionally the month with lowest gonorrhea incidence in the United States; had they arrived in mid-summer, the excess morbidity would have been attributed to the increase normally observed during the third quarter of the year. In any event, superb casefinding efforts sufficiently interrupted disease transmission to permit a return to normalcy (awful word, non?) by late April.

Two months (May and June) of quiet, mostly "background noise" gonorrhea incidence, and then the second wave hit. A completely different wave. The splash was noted in mid-July and the frothing remained, quite uncharacteristically, through December. This second wave was unexpected, even though it

occurred in the traditionally busy third quarter, and atypical. First, it was a civilian outbreak and second, it was characterized by patients who knew little about their sexual partners. In a memorandum dated 10 September 1984 (Appendix B) we predicted the impact such elusive sexual partners would have on gonorrhea incidence. Indeed, the contrast of the aftermath of each imported wave is striking. Because our troops knew their sexual partners well, control measures were efficacious: within 2 months, the Honduras-derived outbreak was contained. Diligent control measures were also applied during the summer wave but, presumably, the elusive sexual partners sustained transmission for at least five months.

To each wave we attribute roughly one hundred excess cases, perhaps a little more for the summer wave.

Each wave was discouraging for different reasons: the first because it occasioned a furious counter-attack that over-taxed our energies and the second, because it frustrated us (unlocatable sexual partners). Our tenacity yielded laudable results neverless:

II. Case-finding Highlights

A. Despite the large incidence increase, 94 percent (1432/1525) of all gonorrhea cases were interviewed for sexual partner information. A total of 2626 contacts (1.83 per interview) were elicited. These data compare favorably with our best previous efforts: the 1980s.

Contact Interviewing Activity

1977-1984

	1977-1979(Averages)	1980-1982(Averages)	1983	1984
Cases Interviewed(%)	70%	93%	97.3%	94%
Contacts per interview	1.35	1.87	1.8	1.83

B. More importantly, case-finding efficacy was superb in 1984. Of the 2626 contacts elicited 2078 (79 percent) were sought locally. (Thus, one out of five sexual partners resides elsewhere, a good indicator of disease importation - though not the only one, since residents also travel and acquire gonorrhea elsewhere, but their gonorrhea is counted as "local" in our contact reports, e.g. the 2936 form):

Local Contacts to Gonorrhea: Outcomes

	1977-1979 (Average)	1980-1982 (Average)	1983	1984
Infected (New Cases)	194(22%)	380(29.6%)	357(25.9%)	*475(29.8%)
Not Infected	356(40.4%)	500(38.9%)	567(41.1%)	637(40%)
Not Examined	331(37.6%)	405(31.5%)	456(33%)	481(30.2%)
Total Contacts Sought:	881(100%)	1285(100%)	1380(100%)	1593(100%)

* highest percentage and number ever!

Note: Table excludes infected, previously treated contacts requiring no investigation beyond a search of H.D. records (Disposition "3" on 2936)

Rumination: Part of the reason gonorrhea incidence was so high in 1984 is reflected in the Table above: we identified 475 new cases by contact tracing efforts (118 more than in 1983). In one sense, we're victims of our own diligence. This is a better price to pay than permitting entrenchment of the disease through sloppy case-finding. (Easier-to-pay-now-than-later idea.)

III. Gonorrhea: Reason For Presentation (Epidemiologic category)

	Reason for presentation	
	1983	1984
Volunteer	712(55.6%)	838(55%)
"Screenee"	153(11.9%)	170(11.1%)
Contact	415(32.5%)	517(33.9%)
Total Cases	1280(100%)	1525(100%)

And, historically (percentages only).

	1976	1977	1978	1979	1980	1981	1982	1983	1984
Volunteer	63.1	62.2	61	62.8	57.3	51.7	58	55.6	55
"Screenee"	11.4	10.7	11.7	10.1	9.9	8.3	8	11.9	11.1
Contact	25.5	27.1	27.3	27.1	32.8	40	34	32.5	33.9

The trend is remarkably constant for "screenees" (epidemiologically passive cases). The gradual decrease in the proportion of volunteers is balanced by the gradual increase in contacts. It reflects the greatly intensified (> 90% of reported cases being interviewed) case management efforts of the 1980s. In short, the more active the control efforts, the greater the proportion of cases classified as contacts.

IV. Gonococcal pelvic inflammatory disease (PID)

It is reasonable to suspect that superior control efforts curtail the burden of complications (e.g. PID). In Annual Report 1983, we suggested that importation was implicated in the unusually large 1983 PID incidence. The 1984 PID burden is not only back to acceptable levels, but the lowest, numerically and proportionally, ever (along with 1981).

	1976	1977	1978	1979	1980	1981	1982	1983	1984
Cases:	130	111	85	84	84	76	79	108	75
Pct:	(18.3)	(15.5)	(15.4)	(16)	(14)	(12.5)	(17.3)	(21)	(12.7)

Note: Pct = percent of total infected women

V. Asymptomatic men

Diligent pursuit of asymptomatically infected men continued; there were fewer, proportionally, in 1984 because there were fewer PID cases.

Year	Asymptomatic	All men*	Pct. Asymptomatic
1981	143	927	15.4
1982	116	814	14.3
1983	131	777	16.9
1984	139	936	14.9

* (97 percent are urethrally positive; the rest, rectally or/and pharyngeally)

VI. Gonorrhea repeat cases

Of the 1525 cases of gonorrhea reported in 1984, 132 were repeat episodes (8.6 percent), a pronounced increase over 1983 (6.9 percent). However, the rate fluctuates a bit, even during years of exceptional control efforts (1980 on).

Gonorrhea repeat cases

Year	Cases	Percent of all cases
1973	159	9.9
1974	180	11
1975	129	7.7
1976	170	8.6
1977	229	11.5
1978	138	9.1
1979	156	10.2
1980	129	8.5
1981	136	8.8
1982	86	6.8
1983	89	6.9
1984	132	8.6

In terms of bodies, 110 persons were repeaters; 94 had 2 episodes, 12 had 3 each, 2 had 4 each, and 2 had 5 each. Thus these 110 persons generated 242 cases in all.

Characteristics of repeaters:

a. 70 of 110 repeaters (63.6%) are men
b. 42 of 70 male repeaters (60%) are military
c. 43 of 48 military (male and female) repeaters are black, with these accounting for 41 percent of all repeat cases.
d. Under-representation award:
   1. 2 of 40 women repeaters are prostitutes (one repeat case each)
   2. 7 of 70 male repeaters are homosexual (11 repeat cases in all)

VII. Field investigations

A total of 2595 investigation reports (2936s) were closed in 1983, the second highest number ever (2729 in 1981). (Field investigations include syphilis contacts, positive serology and positive GC culture report follow-ups, and GC contacts.) The mean for the last 12 years is 1851 and the median, 1778.5. All this in way of saying, Dr. Muth, that we worked our tails off, OK?

a. A total of 639 (30.4 percent) were newly identified infections (475 GC contacts + 147 GC cultures + 17 positive serologies).

b. About 55 percent were completed within 3 working days of assignment and 73 percent within 7 days. Pepi epi, right?

c. About 19 percent of reports had unsuccessful outcomes (unable to locate individual).

VIII. Gonorrhea in street prostitutes

There were 271 visits to the clinic on the part of street prostitutes during 1984 (258 original visits and 13 follow-up visits), a 12 percent increase over 1983 (Police surveillance is always more assiduous in election years), yet only 23 cases of gonorrhea were identified, the lowest percentage ever.

Year	Original Visits	Cases	% positive
1970-1975(Averaged)	133(Average)	39(Average)	29.3(Average)
1976	341	119	34.9
1977	311	57	18.3
1978	348	32	9.2
1979	204	36	17.6
1980	228	21	9.2
1981	186	35	18.8
1982	198	27	13.6
1983	214	31	14.5
1984	258	23	8.9
Total: 15 years	3086	615	20 percent

IX. Gonorrhea in homosexuals

AIDS - phobia continues to deter indiscriminately promiscuous behavior among local gays. During the 4th quarter of 1984, however, we noted a small surge in gonorrhea cases among gay men. Too soon to suspect that the trend is reversing; anecdotally, though, we note that gays are beginning to perceive that what is amazing about AIDS is how few cases are occuring. This perception may affect their sexual practices in the near future.

Percent of male gonorrhea cases: gay men

Before AIDS (1-6/'81)	16.2%
AIDS reported (7/'81-12/'81)	9.4%
1982	6.9%
1983	7.2%
1984	6.5% (lowest ever!)

X. Gonorrhea by aggregate report source

The recent advent of immediately accessible and price-competitive medical care facilities (Emergicare) and of pre-paid health plans (Peak Health, HMOs etc.) has helped shift part of the gonorrhea burden back to the private sector, reversing the 1973-1982 trend (See Annual Report '82). The implications are chiefly operational: it takes 3 to 4 times as much energy to conduct case management on a private sector case than a public, or military, sector case.

In 1973, 23.3 percent of all cases were reported from the private sector; by 1982, only 13.6 percent were reported. The shift occurred in 1983 (19 percent) and continued in 1984 (17.8 percent).

XI. Unreported cases

About one half of one percent of gonorrhea cases are not spontaneously reported in El Paso County...

Year	Cases Not reported (%)
1981	7 (0.45)
1982	5 (0.4)
1983	12 (0.94)
1984	9 (0.6)
	33 (0.58)

XII. Gonorrhea case rates

These data attenuate (a bit) the drama of 1984's 20 percent increase. (JBM: you wanted rates, you got 'em.)

Gonorrhea Rates (cases/100,000)

1970	1973	1977	1980	1981	1982	1983	1984
667	~700	~735	491	473	387	387	459

We have the same number of GC cases as 1979 and 1980, but rates are 6.5 percent lower because the population increased 7.3 percent (309,424 to 331,988) from 1980 to 1984.

XIII. Fort Carson Gonorrhea Program

This crucial Program performed well in 1984, though the intense counter-attack to stem the Honduras-derived outbreak and the chronic personnel shortage both served to exhaust George Ware, who suffered from "burn-out" for several months.

Gonorrhea incidence at Fort Carson increased 24 percent during 1984, with about 60 percent of that increase attributable to the Honduras-derived outbreak, and the rest to increased importation of cases from the fall to the end of the year.

Fort Carson Gonorrhea Cases

(1973 - 1984)

Year	Men	Women	Total Cases	Percent of overall Cases in County
1973	510	50	560	(35)
1974	509	22	531	(32.6)
1975	506	33	539	(32)
1976	663	29	692	(35)
1977	697	48	745	(37.3)
1978	521	49	570	(37.6)
1979	571	50	621	(40.7)
1980	546	110	656	(43.2)
1981	528	115	643	(41.8)
1982	501	108	609	(48.2)
1983	431	88	519	(40.5)
1984	534	110	644	(42.2)

A. Fort Carson: Gonorrhea interviews

"Burn-out" served to slightly depress the quality of interviews, particularly during the second and third quarters of 1984. Nevertheless, 96 percent (619/644) of cases were interviewed, yielding a commendable 1.62 contacts per interview. Historically...

Year	No. of interviews	Contacts Elicited	Contact Index
1977	626	388	0.62
1978	570	419	0.74
1979	645	534	0.81
1980	574	865	1.5
1981	632	1144	1.8
1982	605	1100	1.8
1983	516	868	1.7
1984	619	1003	1.62

B. Fort Carson: Contact tracing outcomes

This was the Fort Carson Program's second best year ever in terms of contact tracing outcomes. Three markers are important: 1) the number of cases newly identified as a result of case-finding ("brought to treatment"); 2) the number of exposed persons preventively treated ("epi treated"); and 3) the proportion of contacts sought that could not be found.

Contacts to Fort Carson cases

Year	New Cases Identified ("Brought")	No. "Epi Treated"	Unable to locate
1977	70	79	42%
1978	53	42	50%
1979	57	81	55%
1980	119	82	36%
1981	235	195	29%
1982	199	160	27%
1983	148	157	29%
1984	203	185	27%

The 203 newly identified cases represent an astonishing 36 percent of all contacts to Fort Carson cases sought locally (excludes disposition "3" on 2936). Another indicator of quality interviewing is represented by the 27% "unable to locate" rate, virtually the lowest ever. Mr. Ware deserves most of the credit for producing such indices during a difficult year.

Ruminations

Given a certain level of disease prevalence, an increase in incidence can be caused by intensification of transmission locally, by exogenous introduction of cases, or a mixture of both.

An increase in endogenous transmission is contingent on intensification of sexual activity, or an increase in the number of susceptibles, or by an increase in the amount of time sexually active, infected persons remain in the disease pool.

Our assertion is that most of the increase in gonorrhea incidence noted in 1984 can be attributed to exogenous introduction, temporally divisible into two waves. Do the data - inelegantly and tediously presented above - provide supportive evidence? (It is, after all, so much easier to point the finger elsewhere. Sort of a cowardly rationalization for Program ineptitude.)

The datum most strikingly supportive of our view is the magnitude of the incidence increase. Even during the great epidemic, national rates ranged roughly from 5 to 15 percent, with 10 percent a common occurrence. There certainly has not been a 20 percent increase in sexual activity locally. Not only are the mid-1980s not the libertine 1960s, but AIDS/Herpesphobia has probably reduced the number of adventurers in the sexual marketplace.

With the exception of the slight increase in the number of repeat infections, none of the 1984 data suggests poor control efforts. Au contraire: in the crucial categories (proportion of cases interviewed, contact indices, number and proportion of newly identified cases, low rate of complications, high percentage of asymptomatic men identified, speed of contact tracing process, virtual absence of infection among prostitutes and homosexuals), the Program produced superb outcomes. The best. Such quality efforts militate against entrenchment of disease on a community (increase in prevalence) or individual (duration of infection) level. Thus neither increase in sexual adventurism nor of duration of infection at the local level, can be recruited as explanations of the 1984 increase.

Has there, then, been an increase in the quantity of susceptibles? Very possibly. El Paso County, lilly-white until the late 1960s, has become increasingly diversified ethnically. For example, the proportion of blacks in our population increased from 5.2 to 6.2 percent from 1970 to 1980. It is likely the rate is currently accelerating, particularly since Fort Carson increased Post troop strength in the early 1980s (Reganism). We estimate that blacks now represent 7 or 7.5 percent of the population.

For the reader who may be skeptical that such a modest increase in representation can have substantial impact on gonorrhea incidence, it should be recalled that blacks have accounted for 50-53 percent of cases since 1981.

Young black men, many of whom are soldiers, comprise a very mobile group, travelling home frequently. Home is generally in areas of very high disease prevalence: the U.S. South, particularly the Southeast.

The evidence for exogenous introduction of cases during the first wave is as clear as epidemiologic evidence can be. The Honduras-related wave accounts for nearly half of the 1984 incidence increase. Support for ascription of exogenous origin of the summer wave is not as straightforward. The fact that it occurred in the summer, at a time when incidence increase is expected, blurs the evidence. And yet we are convinced of its exogenous origin. First, disease levels were back to normal for the two months preceding July, and probably too low to generate the fury of July and August, not to mention the fourth quarter (see Table, rear of Report, "Gonorrhea Morbidity, 1973-1984"). The best support emerges from an obscure datum in a table (rear of Report, "Monthly GC investigations report... where the salient data are circled ([ellipsed?]). The annual proportion for "unlocatable contacts" (read: unable to even initiate search efforts for this person) is about 7 percent. Not only was it 9 percent for 1984, but most of the increase occurred in the summer. What of it as an indicator? We know that the persons most likely to be transmitters are stable in our community <u>and</u> tend to know their sexual partners well enough to locate them for examination. The high number of "unlocatable" contacts elicited during the summer months suggests evanescent sexual partnerships characteristic of transients or recent arrivals. To record as many cases in the fourth (400) as in the third (408) quarter can best be explained by the presence of a reservoir created by new arrivals during the summer. New arrivals who remained in the county long enough to plant roots became easier to identify (and locate) by the sexual partners they infected during the fourth quarter (because, by that time, they would have presumably joined the local gonorrhea social networks, as it were).

P.S. Do the above imaginative constructs/ruminations work, Dr. Muth, or are we fired?

PART TWO

(Mercifully short)

MISCELLANEOUS DATA

I. <u>VD Clinic attendance...</u>

... was numerically intermediate between 1982 and 1983's:

Year	New Visits	Return visits	Total
1982	2135	1721	3856
1983	2218	1691	3909
1984	2234	1650	3884

II. Non-reportable STDs in V.D. Clinic

Data for non-reportable STDs were first recorded in a systematic way during calendar 1982. Although these data are not catholic (only VD Clinic is included), they support the idea that sexual adventurism may be declining. Who knows?

Infection	Men			Women		
	1982	1983	1984	1982	1983	1984
NGU	569	552	512	--	--	--
Trichomoniasis	--	--	--	461	492	390
Monilia	--	--	--	456	463	391
Non-specific vaginitis	--	--	--	250	279	257
Genital Herpes (1st Episode)	70	83	34	51	59	25
Venereal warts	131	185	127	55	62	49
Scabies	17	21	15	4	4	3
Phithirus Pubis	56	59	44	29	31	22

III. Syphilis

Speaking of exogenous introduction, what other disease could have been well represented in El Paso County during a year of national syphilis incidence decline (minus 15 percent)?

Year	Infectious Syphilis	Late Syphilis	Total
1973	50	47	97
1974	52	17	69
1975	48	20	68
1976	39	17	56
1977	20	12	32
1978	26	19	45
1979	19	8	27
1980	23	4	27
1981	16	3	19
1982	18	7	25
1983	15	9	24
1984	26	4	30

Summary

Calendar 1984's control efforts consumed a tremendous amount of energy, allowing no time for the pursuit of controlled investigation or for writing papers. Football played well by returning to the fundamentals. Not much fun, but effective.

Faithfully submitted,

John Potterat
Program Guru

Christopher Pratts
Epidemiologist

Rita J. Dawson
Coordinator/Secretary

P.S. For readers unfamiliar with our Program, the extent of disease importation is quantified for El Paso County in A civilian-military partnership for the reduction of gonorrhea incidence, due to appear in the Jan-Feb '85 issue of Public Health Reports; the "gonorrhea social networks" are described in Gonorrhea as a social disease, due to appear in the Jan-Mar '85 issue of STD.

PART THREE

1. Appendix A
2. Appendix B
3. The traditional, soporific tables

EL PASO COUNTY HEALTH DEPARTMENT
501 North Foote Avenue
Colorado Springs, Colorado 80909

To: John B. Muth, MD, FACPM
From: John Potterat, V.D. Control
Subject: March, 1984 Gonorrhea Outbreak
Date: 5 April 1984

Summary

Gonorrhea incidence in El Paso County increased dramatically during March of 1984. Fort Carson personnel and their sexual partners account for virtually all of the "excess" cases noted. Sudden case influx is directly linked to the return of our troops from Honduras starting in early February. Application of vigorous case-finding measures by our staff and, particularly, by George Ware of the Fort Carson Preventive Medicine Section, will quickly contain this outbreak.

Background

1) As detailed in Annual Report 1983 gonorrhea incidence at Fort Carson has declined substantially since the assignment on post of a trained civilian V.D. epidemiologist. Fort Carson incidence, for example, was 15 percent lower during 1983 compared to 1982. This rate of decline continued into 1984: for the first two months of this year, Fort Carson gonorrhea incidence was 15 percent lower than during the comparable period in 1983! And then came March...

2) For March, 1984 we observed 161 cases of gonorrhea in the County, approximately 50 percent more cases than expected. It is the biggest March incidence on record (12 years; mean= 111 cases; range= 73-154), and the biggest monthly incidence in 50 months (164 cases in January of 1980).

3) Fort Carson reported 81 cases, more than twice the expected number for this time of year. It is the largest caseload at Fort Carson in 7 years (92 cases in June of 1977).

Characteristics of Excess Cases

Analysis of the "excess" cases does not suggest local endemic foci suddenly coming to flower. Rather, it indicates recent, exogenous introduction of disease.

Comparison of March, 1984 case distribution with February, 1984 or March, 1983, clearly shows that "excess" cases are 1) Fort Carson men with acute urethral infection of recent origin and 2) their sexual partners, who acquired disease elsewhere and imported it here. The "excess" cases are NOT among 1) gay men (who are still gun-shy because of AIDS) , 2) street prostitutes (one case among 23 prostitutes examined), or 3) repeaters, nor do they 4) suggest "historical" infection (since there was no increase in routine discoveries or GC PID cases).

Origins of the Outbreak

The "excess" cases attributed to Fort Carson personnel and their sexual partners did NOT originate in Honduras (only two did). Rather, they are a

consequence of the troops being granted leave to visit home before reporting to Fort Carson again, and/or of their sexual partners arriving in the Springs to greet (I almost typed "gleet" them!).

The Riposte

Vigorous case-finding - high caliber contact interviews and diligent contact tracing - is containing the outbreak. George Ware literally did two months' worth of case-finding during March. (We could not, incidentally, be prouder of his counter-attack.)

I will mercifully spare you the soporific details, though I wish to emphasize a couple:

1) All Fort Carson cases were interviewed, yielding a solid 1.7 contacts per interview (97 percent of civilian cases were interviewed during the same interval).

2) A total of 188 "contact-to-gonorrhea" reports were investigated, with 58(!!!) cases newly identified as a consequence. (A normal month yields about 25-30.) Talk about quality work.

Ruminations

The aggressive public health counter-attack, especially at Fort Carson, will prevent recently introduced cases from getting entrenched in the local gonorrhea-prone population. Of that, you can be confident. Of far greater significance is what I call the Fort Carson Phoenix Effect: we cannot underestimate the tremendous potential of Fort Carson personnel to episodically introduce exogenously-acquired gonnorrhea into the community on a large scale. Relaxation of vigorous case-finding would surely permit gonorrhea to re-establish itself on an endemic, rather than epidemic, basis. The pivotal importance of quality case-finding services at Fort Carson is once again emphasized by current events. Eternal vigilance and all that...At least until vaccines arrive.

cc

LTC Breeden, Chief Of Preventive Medicine Service, Fort Carson.
Richard Hopkins, MD, Chief of Epidemiology, Colorado Department of Health.
Frederick C. Wolf, Chief, Venereal Disease Control, Colorado Department of Health.

EL PASO COUNTY HEALTH DEPARTMENT
501 NORTH FOOTE AVENUE
COLORADO SPRINGS, COLORADO

TO: Medical Director

FROM: V.D. Control

DATE: September 10, 1984

SUBJECT: Commentary, August 1984 Monthly Report

Gonorrhea morbidity remains at unexpectedly high levels. A total of 1012 cases have been reported, compared to 828 (+22.2%) for the same period in 1983. Two "waves" account for the excess cases: the (Honduras-derived) Spring outbreak and the current one. This latter is occurring in the civilian sector. (Fort Carson reported surprisingly few cases this month.) Importation is probably responsible but difficult to document since a disproportionate share of named sexual partners are being classified as unlocatable (information insufficient to even attempt field follow-up).

Implications: If these elusive sexual partners remain in the County, we can expect sustained, high disease levels through November.

Final note: Despite the unusually high rate of case-finding slippage, aggressive contact-tracing is yielding fine results. Although morbidity is up 22%, the "brought-to-treatment" rate is up 37%: 321 infected contacts newly identified (vs. 234 for same period in '83). In fact, we had 357 infected contacts newly identified for Calendar 1983; we"re almost there by August of this year!

P.S. Prostitutes are mercifully underrepresented: five cases in last 90 days!

EL PASO COUNTY GONORRHEA MORBIDITY
1973 - 1984
By Month

Year	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Monthly Average	Annual Total
1973	175	150	102	93	122	122	134	149	188	124	146	93	133	1598
1974	110	79	108	133	138	143	203	198	127	155	101	134	135	1629
1975	133	138	122	145	116	126	191	186	171	124	82	146	140	1680
1976	140	119	154	138	158	155	185	L. Hill 174	246	131	213	165	165	1978
1977	193	117	133	182	161	215	134	193	149	145	212	164	167	1998
1978	134	124	107	128	112	134	119	136	129	137	137	118	126	1515
1979	161	106	97	106	105	117	130	175	Washoe 166	117	136	109	127	1525
1980	164	149	73	118	109	122	156	170	98	118	126	117	127	1520
1981	117	120	126	118	140	174	137	148	99	144	128	86	128	1537
1982	95	96	98	83	94	127	115	149	118	97	94	97	105	1263
1983	113	97	108	97	87	98	118	110	128	148	90	86	107	1280
1984	96	115	161	127	105	113	153	142	113	133	131	136	127	1525
1985	98	96	98	138	132	127	179	155	127	157	97	126	128	1530

Monthly Venereal Disease Morbidity Report

CALENDAR 1984

Reporting Source	Morbidity				Age Group										Race			Pro	EX
	Syphilis			Gon	14-19		20-24		25-29		30-39		40+		Cav	Blk	Hisp	Syph	Gon
Categories	P&S	E.L.	Other		Syph	Gon	Syph	Gon	Syph	Gon	Syph	Gon	Syph	Gon					
Private Physician Men	2	1		94		12	1	32		27	2	18		5	45	24	28		
Women		1	2	144	1	47		56	1	28		12	1	1	69	62	16		
V.D. Clinic Men	1	4	1	278	1	42	2	100	1	83	1	42	1	11	106	131	47	5	277
Women	2	3		269	3	99		104	2	42		22		2	118	109	47	2	287
CHC/Pren/Family P.				34		9		14		4		4		3	12	10	12		
Planned Parenthood				20		12		5		2		1			12	2	6		
Health Hold				8		5		1		1		1			4	3	1		
Fort Carson Men	5	5		534	2	87	4	317	3	98	1	28		4	100	400	44		
Women				110		27		69		14					43	57	10		
Ent Air Base Men		2		21		6		10	1	3	1	2			8	12	3		
Women				4		1		1		1		1			1	2	1		
Air Academy Men				9		3		4				1		1	6	3			
Women			1						1						1				
Totals	10	16	4	1525	7	350	7	713	9	303	5	132	2	27	525	815	215	7	564

Clinic Attendance: 3884 ($4827: incl. $510 for Heptavax & $584 for Medications)
New: 2234
Return: 1650

ER Males: 38
ER Females: 59

Above includes: One neonatal GC case (ophthalmia)
3 DGI/ 2 prepubertal GC and,
1 Congenital Lues neonate

Treatment Failure Two Clinic, One PMD, cases

MONTHLY G.C. INVESTIGATIONS REPORT: EL PASO COUNTY HEALTH DEPARTMENT, 1984

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	CY84	PCT/TL
CONTACTS TO GONORRHEA: OUTCOME														
NOT INFECTED	1	1	1	5	3	1	0	1	1	1	2	2	19	0.91
BROUGHT - TX	28	25	58	52	25	43	45	45	27	54	34	39	475	22.86
PREVIOUS TX	28	19	42	59	25	24	50	43	25	68	35	35	453	21.80
NOT FOUND	25	11	19	16	29	29	4	29	10	20	18	36	246	11.84
REFUSED EXAM	6	0	6	6	2	5	0	6	1	12	2	2	48	2.31
UNLOCATABLE	4	1	1	10	2	11	7	32	26	46	6	41	187	9.00
TRANSFERRED	0	1	5	1	9	2	3	3	5	1	1	1	32	1.54
EPI TREATED	24	32	56	82	38	52	46	59	40	74	46	61	610	29.36
OTHER	0	0	0	0	0	1	2	0	1	1	1	2	8	0.38
TOTAL	116	90	188	231	133	168	157	218	136	277	145	219	2078	100

MONTHLY FIELD ACTIVITY REPORT

District El Paso County

Representative Potterat

Month/Date Calendar 1984

Gonorrhea Morbidity

	Male	Female	Total
Civilian	372	475	847
Military	564	114	678
Total	936	589	1525

Gonorrhea Counseling

	Male	Female	Total
Public			
Private			
Military			
Total			

Syphilis Interviews: OI 27 RI 20 CI 42

Consultation Visits: Lab 2 Health Dept/PHN _____ PMD 4

GC Interviews:	Male	# Contacts Initiated	Female	# Contacts Initiated	Total	# Contacts Initiated
Clinic Volunteer	189	333	223	523	412	856
PMD	63	89	139	280	202	369
Asymptomatic Male	80	184			80	184
Hospital Females						
PID			48	104	48	104
Repeaters	17	24	21	43	38	67
Total	349	630	431	950	780	1580
Military	540	841	104	205	644	1046

Field Investigations:	# Closed	# Exam	0-3 Days	4-7 Days	"1"	"X"
Syphilis Contacts	45	38	23	7	6	9
Reactors	74	69	36	16	11	
Suspects, Associates						
Gonorrhea Cultures	398	397	197	89	147	
Gonorrhea Contacts	2078	1598	893	265	475	610
Other						
Total	2595	2102	1149	377	639	619

MONTHLY V.D. CLINIC AND LABORATORY REPORT: EL PASO COUNTY HEALTH DEPARTMENT, 1984

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	CY84	POS.	PCT+
TESTING:															
RPR	203	231	224	238	227	181	290	303	213	269	240	234	2853	97	3.40
FTA	4	6	3	1	7	6	6	6	4	9	7	14	73	34	46.58
DF	1	1	1	0	0	1	1	0	2	2	0	5	14	2	14.29
GC SMEAR	143	127	138	140	134	115	151	172	130	160	151	140	1701	228	13.40
GC CULTURE:															
VDC MEN	186	157	170	157	160	148	189	202	162	196	196	180	2103	300	14.27
VDC WOMEN	101	89	117	133	114	103	126	171	109	130	135	101	1429	264	18.47
PNC WOMEN	37	40	41	41	44	47	55	37	35	42	34	28	481	3	0.62
FPC WOMEN	39	30	18	31	24	18	24	38	16	36	23	22	319	10	3.13
PMD WOMEN	240	235	232	233	196	196	248	250	174	227	191	146	2568	44	1.71
CHC WOMEN	98	86	103	125	112	76	134	144	83	122	139	77	1299	24	1.85
TOC :ALL PTS	31	39	42	53	20	41	36	45	35	37	27	33	439	27	6.15
TREATMENT:															
GC TREAT	32	61	56	55	40	44	62	79	52	56	50	47	634	NA	NA
GC PRO TREAT	23	47	43	62	35	38	53	59	37	58	57	52	564	NA	NA
LUES TREAT	1	0	2	0	2	2	0	2	3	2	3	4	21	NA	NA
LUES PRO TREAT	0	1	0	0	2	0	1	0	0	2	0	1	7	NA	NA
NON-V.D. TREAT	125	125	133	154	144	116	199	186	129	175	146	130	1762	NA	NA
CLINICS: NO.	13	13	13	13	13	13	13	14	12	14	12	13	156	NA	NA

EL PASO COUNTY HEALTH DEPARTMENT

501 NORTH FOOTE AVENUE • COLORADO SPRINGS, CO 80909

AIR POLLUTION CONTROL: 712 SOUTH TEJON, 80903 • 636-0137
CODE ENFORCEMENT: 105 EAST VERMIJO, SUITE 350, 80903 • 471-6878
DRUG TREATMENT PROGRAM: 710 SOUTH TEJON, 80903 • 636-0150
VITAL STATISTICS: 27 EAST VERMIJO, 80903 • 471-5762

V.D. Clinic

Summary of Medications Used

1/1/'84 -- 12/31/'84

APPG (6 m.u. vial)	194
BICILLIN (1.2 m.u. syringe)	73
TROBICIN (2g. vial)	86
BENEMID (500 mg.)	2280
AMPICILLIN (500 mg.)	8190
TETRACYCLINE (SHD)	250
TETRACYCLINE (CHD)	29050
BENADRYL (50 mg.)	350
E-MYCIN (250 mg.)	580
DOXYCYCLINE (100 mg.)	4500

Note: In addition, the following were provided to CHC (They are NOT included above):

Tetracycline (500 mg.)	4000
Ampicillin (500 mg.)	2000
Probenicid (500 mg.)	700
Spectinomycin (2 mg.)	17
Procaine Pen (6 m.u.)	9
Doxycycline (100 mg.)	1500