President’s Column

Although there have been no specific IUSTI meetings since my last letter the spring has seen a flurry of activity in relation to ongoing IUSTI programmes and the organisation of educational events for 2013-14.

The world meeting 2013
The 14th IUSTI World congress will take place in Vienna 14-17th of July. This meeting is being held in conjunction with the biennial ISSTDR and both organisations have extremely high expectations of the event. Prof Starry and I are co-chairs of the event and Prof Tom Quinn of Johns Hopkins is the chair of the scientific committee. The organisers have devised a program that will do justice to the high quality of science we expect of the ISSTDR and the focus on clinical and translational medicine that IUSTI epitomises. The call for abstracts has had an exceptional response and we expect the meeting, to be held at the Hofburg palace in central Vienna, to be extremely well attended. The organisers have secured substantial support from international donors and the meeting has set up a significant substantial scholarship fund administered by Prof David Lewis the incoming IUSTI president. This should allow young scientists and workers from developing regions to take advantage of attendance and there is every expectation that we will have a truly global representation of STI experts and program workers.

Plans for 2014
The world meeting in 2014 will take place in May in Atlanta, Georgia, USA. Prof David Lewis (World IUSTI), Dr Bradley Stoner (IUSTI North America chair and ASTDA President) and Dr Gail Bolan (CDC) are leading on organisation whilst Dr Sevji Aral (IUSTI Senior Counsellor) will be chairing the scientific committee. The CDC and ASHA have a track record of considerable success with these events and IUSTI is delighted to be part of this. Dr Patricia Garcia the Regional Director for Latin America is closely involved with the organisation to ensure the program is attractive for Latin American members.

Legacy funding from IUSTI 2011 World meeting
The organisers of the 2011 World meeting in Delhi have returned to IUSTI a significant surplus which is to fund a substantial program of education in the Region. There is also provision within the original Memorandum of Understanding for the Union to develop scholarships to our world meetings and a named lecture. The Union is currently discussing with the organisers of the meeting the exact arrangements for these provisions and we plan to make a full detailed announcement to the General assembly in Vienna.

Sad News from Asia Pacific Region

It was with great sadness that we learnt of the death of Dr Hemendra Doshi, past regional Chair of the Asia Pacific Region. Having trained in India he established a highly successful clinical practice in dermatology in Malaysia in the 1980s. At a time when STI care was marginalised he trained in and became highly specialised in STI management. He championed the training of skilled dermatovenerologists in south east Asia and set up a number of successful training initiatives, founded academies and specialist societies, as well as establishing diplomas and prizes. Mentorship was a tremendously important part of his life and he encouraged a generation of junior doctors to enter the field and practice to the highest standards. His achievements were recognised not just within Malaysia but also internationally. Most recently for his services to education he received the IUSTI...
silver Medal and was honoured by the Royal College of Physicians of London with a Fellowship of their college.

IUSTI at 90
2013 will mark the 90th year of IUSTI’s founding. The Union is marking the occasion with events throughout the year. We have much to celebrate - the Union is stronger then ever (five fully functioning Regions) and a growing active membership. National IUSTI groups are developing strength in important regional areas such as IUSTI Russia and in central Asia. We have a track record of excellent scientific and training events, the production of important Regional guidelines as well as working closely with the partners.

Raj Patel
IUSTI President

Regional Reports

Europe
Since my last report Prof Mikhail Gomberg from Moscow has been elected by the IUSTI Europe Council as our new Treasurer. Mikhail is a longstanding and active supporter of the IUSTI, as the Russian national representative on the Council, as the founding Chair of the Russian IUSTI Association and also as a Senior Counsellor on the World IUSTI Executive Committee. I am sure that Mikhail will do an excellent job on behalf of the Branch. He replaces as Treasurer Dr Simon Barton from London and on behalf of the Officers and Council I should like to thank Simon for all his contributions over many years, especially the excellent job he did as Chair of the International Scientific Committee for the IUSTI Europe meeting in Tbilisi, Georgia in 2010. Following discussions at the World IUSTI Executive Committee meeting in Melbourne late last year, our Membership Secretary Dr Jackie Sherrard has successfully initiated a round of annual European membership subscriptions. Membership for European members will now run from 1st January each year and are renewable each year. Anyone who is not a member and who would be interested in joining is encouraged to contact Jackie at: jackiesherrard@doctors.org.uk

We are all looking forward very much to the IUSTI/ISSSTDR conference that will take place in Vienna, 14-17 July. The meeting has the title, ‘Threatening past, promising future’ (see: www.stivienna2013.com/). The Congress President is Prof Angelika Stary, the Chair of the International Scientific Committee is Prof Thomas Quinn and the Chair of the Local Organising Committee who is also the Secretary of IUSTI Europe is Dr Claudia Heller-Vitouch.

In 2014 the IUSTI Europe Congress will take place in Malta, 17-20 September. The President of the Congress will be Dr Joe Pace and in February, Dr Airi Poder (Chair, IUSTI Europe) and myself conducted a site visit to meet Joe and his local colleagues and to inspect possible venues for the Congress. It was a highly successful visit and Airi and I were both tremendously impressed by the beauty and history of the island and by the enthusiasm and charm of Joe and his local colleagues. We are sure that it will be a very successful and popular meeting. The conference venue will be the Radisson Blu St Julian’s (see: www.radissonblu.com/stjuliansresort-malta).

Dr Jackie Sherrard (Membership Secretary) has kindly accepted our invitation to be the Chair of the International Scientific Committee and she is planning to visit Malta in the near future to meet with Joe and his colleagues to start planning the scientific programme.

In 2015 the congress will take place in Barcelona and the President will be Dr Martí Vall Mayans. The meeting is provisionally scheduled for September and Marti is currently enlisting the support of regional (Catalonian) and national (Spanish) professional associations.

I am pleased to report that I have received a formal letter from Dr Viktoria Varkonyi, President of the Hungarian STD Society, confirming the society’s intention to host the IUSTI Europe Congress in Budapest in 2016.

I should also like to mention two other meetings that will take place in the European region:
1. Mikhail Gomberg has organised an STI symposium as part of the 6th Moscow conference of Dermato-venerologists, 20-23 March;
2. The third congress of the Euro-Asian Association of Dermato-venerologists will take place in Odessa, Ukraine, 31 May-4 June 2013. As in the previous two congresses, Mikhail Gomberg has successfully organised a substantial STI track at which a number of International speakers will be participating (see: www.eaad2013.org/).

The work of the European STI Guidelines Project continues. I am pleased to report that the project has obtained the endorsement of the European Society of Clinical Microbiology and Infectious diseases (ESCMID, see: www.escmid.org/); Prof Mario Poljak from Slovenia has joined the Editorial Board as the official liaison with ESCMID. The guideline on, ‘Organising a consultation for STI’ is now on the guidelines section of the European website (see: www.iusti.org/regions/europe/euroguidelines.htm) and has been published in the International Journal of STD and AIDS (2012; 23: 609-612). The revised guideline on pelvic infection has been posted on the website. The revised guideline on gonorrhoea has also
been posted on the website and this is particularly important given the concern over developing antibiotic resistance. Magnus Unemo has published an article in *Eurosurveillance* (2012; 17: 47) drawing attention to the guideline and its implications for clinical practice. The work is ongoing on revising guidelines on: syphilis, proctitis, LGV, hepatitis. A completely new guideline on partner management is in development. The project is also producing patient information in English about all the conditions addressed in the guidelines and these can be accessed at the guidelines web page. At the same page are links to patient information on gonorrhoea in German and information on a range of conditions in Romanian.

Any comments or suggestions on the work of the European Branch or of the European STI Guidelines Project would be welcome. Please email me at k_radcliffe@virgin.net.

Keith Radcliffe

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North America

New CDC Fact Sheet - Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States

In February 2013, CDC published two analyses (1,2) that provide an in-depth look at the severe human and economic burden of sexually transmitted infections (STIs) in the United States. CDC’s new estimates show that there are about 20 million new infections in the United States each year, costing the American healthcare system nearly $16 billion in direct medical costs alone. America’s youth shoulder a substantial burden of these infections. CDC estimates that half of all new STIs in the country occur among young men and women. In addition, CDC published an overall estimate of the number of prevalent STIs in the nation. Prevalence is the total number of new and existing infections at a given time. CDC’s new data suggest that there are more than 110 million total STIs among men and women across the nation. CDC’s analyses included eight common STIs: chlamydia, gonorrhea, hepatitis B virus (HBV), herpes simplex virus type 2 (HSV-2), human immunodeficiency virus (HIV), human papillomavirus (HPV), syphilis, and trichomoniasis.


CDC’s estimates of sexually transmitted infections:

- **Annual new infections**: 20 million
- **Total infections**: 110 million
- **Total medical costs**: $16 billion

**Human papillomavirus (HPV)** accounts for the majority of prevalent STIs in the United States. While there is no treatment for the virus itself, there are treatments for the serious diseases that HPV can cause, and vaccines are available to prevent some types of HPV infection. The body’s immune system clears most HPV naturally within two years (about 90 percent), though some infections persist. While there is no treatment for the virus itself, there are treatments for the serious diseases that HPV can cause, including genital warts, cervical, and other cancers. Most sexually active men and women will get HPV at some point in their lives. This means that everyone is at risk for the potential outcomes of HPV and many may benefit from the prevention that the HPV vaccine provides. HPV vaccines are routinely recommended for 11 or 12 year old boys and girls, and protect against some of the most common types of HPV that can lead to
disease and cancer, including most cervical cancers. CDC recommends that all teen girls and women through age 26 get vaccinated, as well as all teen boys and men through age 21 (and through age 26 for gay, bisexual, and other men who have sex with men). HPV vaccines are most effective if they are provided before an individual ever has sex.

CDC’s STI Screening Recommendations:
- All adults and adolescents should be tested at least once for HIV.
- Annual chlamydia screening for all sexually active women age 25 and under, as well as older women with risk factors such as new or multiple sex partners.
- Yearly gonorrhea screening for at-risk sexually active women (e.g., those with new or multiple sex partners, and women who live in communities with a high burden of disease).
- Syphilis, HIV, chlamydia, and hepatitis B screening for all pregnant women, and gonorrhea screening for at-risk pregnant women at the first prenatal visit, to protect the health of mothers and their infants.
- Trichomoniasis screening should be conducted at least annually for all HIV-infected women.
- Screening at least once a year for syphilis, chlamydia, gonorrhea, and HIV for all sexually active gay men, bisexual men, and other men who have sex with men (MSM). MSM who have multiple or anonymous partners should be screened more frequently for STIs (e.g., at 3 to 6 month intervals). In addition, MSM who have sex in conjunction with illicit drug use (particularly methamphetamine use) or whose sex partners participate in these activities should be screened more frequently.

- POC was estimated to save $5,050 for each case of PID averted, as compared with NAAT.
- Any promising new chlamydia POC test is likely to be cost-effective compared with traditional NAAT in a clinic when specified characteristics are met.

2012 CDC STD prevention meeting

Upcoming Meetings:
STI & AIDS World Congress, Austria, Joint Meeting: 20th ISSTD and 14th IUSTI, 2013
July 14-17, Vienna
2014 U.S. National STD/HIV Prevention Conference, Atlanta, Georgia, USA, June 9-12, 2014

Charlotte Gaydos

Update from WHO

Antimicrobial Resistance in Neisseria gonorrhoea. Time to Act Now.
WHO estimate a total of 499 million new cases of STIs per year in 2008. At any point in time, there are approximately 358.7 million prevalent cases of the four curable STIs in adults, of which 36.4 million are Neisseria gonorrhoeae infections. [1] The rapidly changing antimicrobial susceptibility of N. gonorrhoeae, since the introduction of antibiotics, has created challenges in gonorrhoea control. Because of the widespread resistance, older and cheaper antibiotics have lost usefulness in the treatment. Antimicrobial resistance has regularly appeared and expanded with every release of new classes of antibiotics for gonorrhoea. Emergence of gonococcal resistance to penicillin and tetracycline was identified in Asia during the 1970s and became widespread in multiple regions in early 1980s. In the mid-2000s, high level of resistance to fluoroquinolone emerged.
Only third-generation cephalosporins now remain recommended as first line treatment regimen for gonococcal infections. To date, available data indicates an increasing gonococcal resistance to, and treatment failures with, the last-line oral cephalosporins currently used for the treatment of gonorrhoea. The gonococci involved were also resistant to other antibiotics and has been classified as multi-drug resistance gonococci.

The Gonococcal Antimicrobial Surveillance Programme (GASP) has been documenting the emergence and spread of antimicrobial resistance in gonorrhoea since 1992 and has informed treatment guidelines. WHO recommends that treatment options be refined by data from surveillance of antimicrobial resistance in gonorrhoea and the use of an antibiotic for routine treatment be discontinued when the therapeutic failure and/or antimicrobial resistance reaches a level of 5%.

The GASP is a worldwide laboratory network which is coordinated by regional coordinating centre/focal point. Each designated regional focal point, in partnership with WHO regional office, collate data on antimicrobial susceptibility patterns in gonorrhoea in different countries. The regional focal points provide technical support to countries to strengthen laboratory capacities and an external quality assurance programme including maintenance and distribution of WHO reference panels. [2] Sustaining this programme is essential but challenging. Antimicrobial resistance surveillance is often lacking or of poor quality in countries with high disease rates. There is also general lack of reliable antimicrobial resistance data for gonorrhoea globally and inadequate knowledge of the extent of spread of resistant gonococci.

WHO has recently released surveillance standards and updated the WHO reference panels for the external quality assurance programme to enhance the global surveillance on multidrug and extended-spectrum cephalosporin drug resistant gonorrhoea.[3,4] The WHO standards describe the microbiological and epidemiologic requirements to ensure valid data. In addition, research is underway for new molecular technologies and approaches that could be incorporated with existing methods to address the critical issue of reliable and verifiable antimicrobial resistance surveillance data.

Regions vary on the extent to which countries participate in GASP, and to the specific antimicrobial agents against which resistance is tested. (Table1).

### Table 1: Regional GASP coordinator centres and number of countries participating in the regional Gonococcal Antimicrobial Surveillance Programme (GASP) network

<table>
<thead>
<tr>
<th>Region of the Americas (AMRO)</th>
<th>Number of countries participating</th>
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<tbody>
<tr>
<td>Sexually Transmitted Infections Reference Centre, National Institute of Infectious Disease, Argentina</td>
<td>13 plus US and Canada</td>
</tr>
<tr>
<td>University of Saskatchewan, Saskatoon, Canada</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Disease Prevention Program, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Center for Disease Control and Prevention, USA</td>
<td></td>
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<tr>
<th>East Mediterranean Region (EMRO)</th>
<th>Number of countries participating</th>
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</thead>
<tbody>
<tr>
<td>STD Laboratory, Bacterial Department, National Institute of Hygiene, Morocco</td>
<td>1</td>
</tr>
<tr>
<td>European Region (EURO)</td>
<td>22</td>
</tr>
<tr>
<td>Sexually Transmitted Bacteria Reference Laboratory, Health Protection Agency Centre, United Kingdom of Great Britain and Northern Ireland</td>
<td></td>
</tr>
<tr>
<td>WHO Collaborating Centre for Gonorrhoea and other STIs, National Reference Laboratory for Pathogenic Neisseria, Department of Laboratory Medicine, Microbiology, Örebro University Hospital, Sweden</td>
<td></td>
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</tbody>
</table>

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<tr>
<th>South East Asia Region (SEARO)</th>
<th>Number of countries participating</th>
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<tbody>
<tr>
<td>WHO GASP SEARO Regional Reference Laboratory, VMMC and Safdarjang Hospital, New Delhi, India</td>
<td>6</td>
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<tr>
<th>Western Pacific Region (WPRO)</th>
<th>Number of countries participating</th>
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<tbody>
<tr>
<td>WHO GASP Collaborating Centre WPR and SEAR for STD –Sydney Department of Microbiology, South Eastern Area Laboratory Services (SEALS), The Prince of Wales Hospital, Sydney, Australia</td>
<td>15</td>
</tr>
</tbody>
</table>

Available published data from GASP reported in 2010 showed that majority of countries in Asia, have a high proportion of Penicillin Producing *N. gonorrhoeae* (PPNG) strains. Lower rates of resistance have been reported in the Pacific Island Countries. High rates of PPNG has been observed in the Americas and lower rates of PPNG are observed in European countries. (Figure 1)
Majority of European countries and countries in the Americas except in Bolivia and Brazil have reported high rates of resistance to Ciprofloxacin. Similarly majority of countries in Asia have shown high rates of fluoroquinolone resistance, except for Pacific Island Countries. (Figure 2)

Figure 2: Proportion of N. gonorrhoeae strains resistant to Ciprofloxacin and/or Quinolone reported in countries, 2010

In countries where gonococcal antimicrobial susceptibility surveillance is taking place, there are rising trends of decreased susceptibility in N. gonorrhoeae to ceftriaxone and cefixime. There are 36 countries reporting increasing minimum inhibitory concentration to extended spectrum Cephalosporin - either Cefixime ($\geq 0.25 \mu g/mL$) and Ceftriaxone ($\geq 0.125 \mu g/mL$).[5,6,7,8] (Figure 3). The first reported treatment failures to Ceftriaxone was in Japan[9] followed by more cases of treatment failure in other parts of the world namely Austria, Australia, Canada, France, Norway, Slovenia, Sweden, UK and South Africa,[10,11,12,13, 14, 15] . Majority of reports are from developed countries. This is of greatest concern as it will have a major impact in disease control efforts and reduction in the morbidity associated with gonococcal infections. Widespread antimicrobial resistance will compromise the control of gonococcal infections, increase prevalence of gonorrhoea and its complication. Untreated gonococcal infection will result to increase probability of pelvic inflammatory disease leading to ectopic pregnancy and infertility and disseminated gonococcal infections as well as increase risk of HIV infections. [14] Based on the 2008 global estimates of incident gonococcal infections, the global disability adjusted life years (DALY) generated by gonorrhoea is approximately 440,000. Antimicrobial resistance in gonorrhoea will further increase the burden due to prolonged infections and increase number of people with complications. Moreover the out-of-pocket expenditure of individual will certainly increase due to the higher cost of treating gonorrhoea. [16]

To prevent the serious consequences of antimicrobial resistance in gonorrhoea, action should be taken now to enhance prevention interventions against sexually transmitted infections and ensure rational use of current treatment options to contain the further spread of resistant pathogens. There is also an urgent need to develop new treatment options for N. gonorrhoeae.

To facilitate action against this spread of multi drug resistant N. gonorrhoeae, WHO has launched the “Global Action Plan to Control the Spread and Impact of Antimicrobial Resistance in Neisseria gonorrhoeae”. [17] This global action plan needs to be implemented within the context of enhanced STI surveillance to facilitate early detection of the emergence of resistant strains, combined with a public health response to prevent and treat gonococcal infections and to mitigate the impact of cephalosporin-resistant N. gonorrhoeae on sexual and reproductive health morbidity. The following are priority actions:

- advocacy for increased awareness on correct use of antibiotics among health-care providers and the consumers, particularly in key populations
including men who have sex with men and sex workers
• effective prevention, diagnosis and control of gonococcal infections, using prevention messages, and prevention interventions, recommended adequate diagnosis and appropriate treatment regimens
• systematic monitoring of treatment failures by developing a standard case definition of treatment failure, and protocols for verification, reporting and management of treatment failure
• effective drug regulations and prescription policies
• strengthened antimicrobial resistance surveillance, especially in countries with a high burden of gonococcal infections, other STIs and HIV
• capacity building to establish regional networks of laboratories to perform gonococcal culture, with good-quality control mechanisms
• research into newer molecular methods for monitoring and detecting AMR and development of new treatment options.
• research into, and identification of, alternate effective treatment regimen for gonococcal infections.

Teodora Elvira Wi

References:

Conference Update
IUSTI Events:
STI World Congress 2013 Joint Meeting of the 20th ISSTDR & 14th IUSTI
Dates: 14-17 July, 2013
Location: Vienna, Austria
Website: www.stivienna2013.com

Other STI or Related Meetings/Congresses/Courses:
Immune Activation in HIV Infection: Basic Mechanisms and Clinical Implications
Dates:April 3 - 8, 2013
Location: Breckenridge, Colorado, United States
Website: www.keystonesymposia.org
10th EADV Spring Symposium
Dates: May 23-26, 2013
Location: Cracow, Poland
Website: http://www.eadv.org/nc/news/article/10th-eadv-spring-symposium-1/6/d3c174284f19756946f82f93847b105c/

Somesh Gupta

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STI Global Update is published by the International Union against Sexually Transmitted Infections. Its aims are to provide an international perspective on the management and control of sexually acquired infections. Regular contributions from the regional directors of IUSTI and feedback from conferences is supplemented by short reviews of relevant topics and input from the Center for Disease Control (US), Health Protection Agency (UK), European Centre for Disease Prevention and Control, and the World Health Organisation.

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Further information on the activities of IUSTI available at www.iusti.org