PUBLIC HEALTH MATTERS

A Newsletter for Local Providers and Health Professionals

Fourth Quarter 2007

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Health Officer

Public Health
Prevent. Promote. Protect.

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Transmission of MRSA Infections Through Sexual Contact

Background

Since the mid-1990s, community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) has emerged as a principal cause of community-acquired skin and soft tissue infections. Although 30% of the general population is colonized with *S. aureus,* less than 2% of the general population is colonized with MRSA. *S. aureus*, including CA-MRSA, can cause a wide range of clinical conditions, from folliculitis and furunculitis, to cellulitis and other soft tissue infections with abscess components. Infection may become systemic, and in rare cases CA-MRSA may cause pneumonia, osteomyelitis, pyomyositis, bloodstream infections, and other serious infections.

Outbreaks of CA-MRSA have been documented in a wide range of populations, including children, athletic team members, military recruits, incarcerated persons, injection drug users, men who have sex with men (MSM), and HIV-infected persons. Transmission is primarily through skin-to-skin contact. Skin abrasions, sharing shaving razors, contact with contaminated surfaces and items, chronic skin diseases, and poor hand and skin hygiene increase risk.

By definition, CA-MRSA is resistant to β-lactam antibiotics and also frequently resistant to macrolides and fluoroquinolones. However, most isolates remain susceptible to more than one drug class. Of note, *S. aureus* that is sensitive to methicillin (MSSA) can also be the cause of serious community-acquired infections, so methicillin sensitivity should not be perceived as a marker of less severe infections.

MRSA and Sex

CA-MRSA is not a sexually transmitted disease (STD) as conventionally defined. It is not predominately spread through sexual contact, and mucosal sexual contact has not been found to directly transmit the infection. Nonetheless, close contact that occurs during sex, like other forms of skin-to-skin contact, may allow acquisition of MRSA from an infected or colonized partner. Use of barrier methods such as condoms, while advantageous for STD prevention, will not protect adequately against MRSA transmission if infected skin surfaces are not covered fully.

MRSA in MSM

CA-MRSA outbreaks have been described in MSM. In addition, a recent report by Diep and colleagues (see link to report on page 3) suggested an association between a specific USA300 CA-MRSA strain that was resistant to macrolides, clindamycin, tetracycline, and mupirocin, and male-to-male sex. This is based on retrospective, cross-sectional analyses of MSM in a San Francisco HIV care clinic and a community clinic in Boston from 2004-2006. While all patients with CA-MRSA were HIV-positive in the San Francisco cohort, only 45% of those with the infection in the Boston group were HIV-positive. In this study, 25-37% of infections involved the genitals, perineum, and/or buttocks, which are also common sites of CA-MRSA infection in heterosexuals. Other reports also have shown an increased incidence of CA-MRSA infection in MSM populations. So far, studies have not been able to determine if a causal relationship exists between specific sexual practices and MRSA infection.

Diagnosis and Treatment

Treatment of CA-MRSA should follow the fundamental principles of outpatient management of skin and soft tissue infections (SSTIs). Those involve collection of purulent material (e.g., furuncle, abscess) should be pri-

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Cases of Selected Communicable Diseases Reported to California Department of Public Health

	2006					2007				
	1st qtr.	2nd qtr.	3rd qtr.	4th qtr.	2006 Total	1st qtr.	2nd qtr.	3rd qtr.	4th qtr.	2007 Total
AIDS	12	5	19	22	**58**	13	14	9	23	**59**
Amebiasis	0	1	0	3	**4**	0	2	0	7	**9**
Botulism	0	0	0	0	**0**	0	0	0	0	**0**
Brucellosis	0	1	0	0	**1**	1	0	0	0	**1**
Campylobacteriosis	25	38	45	45	**153**	31	38	49	42	**160**
Chlamydial Infections	690	804	669	1030	**3193**	850	866	807	1007	**3530**
Coccidioidomycosis	9	8	7	18	**42**	6	7	7	32	**52**
E. coli O157:H7 Infection	0	2	5	11	**18**	3	0	2	4	**9**
Encephalitis, Viral	0	0	1	0	**1**	1	0	1	1	**3**
Giardiasis	43	24	24	17	**108**	13	13	29	11	**66**
Gonococcal Infections	177	200	205	208	**790**	227	236	261	286	**1010**
Haemophilus influenzae type B (age<15 yrs)	0	0	1	1	**2**	0	0	0	0	**0**
Hepatitis A	0	1	0	8	**9**	5	0	2	2	**9**
Hepatitis B, acute	1	6	3	6	**16**	2	1	2	1	**6**
Hepatitis C, chronic	151	209	114	148	**622**	147	51	115	618	**931**
HIV infection	0*	2	19	98	**119**	72	66	22	39	**199**
Legionellosis	0	0	0	0	**0**	0	1	0	0	**1**
Leprosy (Hansen's Disease)	0	0	0	0	**0**	0	0	0	0	**0**
Listeriosis	0	0	0	0	**0**	0	0	1	0	**1**
Lyme Disease	0	1	0	0	**1**	0	0	1	0	**1**
Malaria	3	0	0	1	**4**	1	0	0	2	**3**
Measles	0	0	0	0	**0**	0	0	0	0	**0**
Meningitis, Viral	0	3	6	11	**20**	3	4	5	13	**25**
Meningococcal Infections	1	0	2	1	**4**	2	0	1	2	**5**
Mumps	0	0	0	0	**0**	0	0	0	1	**1**
Pertussis	4	20	7	7	**38**	1	4	4	2	**11**
Q Fever	0	0	0	0	**0**	0	0	0	1	**1**
Rabies—animal	0	1	2	0	**3**	0	1	0	2	**3**
Rubella	0	0	0	0	**0**	0	0	0	0	**0**
Salmonellosis	16	19	15	71	**121**	9	8	19	60	**96**
Shigellosis	1	1	7	21	**30**	2	2	4	7	**15**
Syphilis (primary, secondary, early latent)	1	4	2	4	**11**	3	2	5	6	**16**
Tuberculosis	2	6	11	59	**78**	3	11	6	31	**51**
Typhoid Fever	0	0	0	1	**1**	0	0	0	1	**1**
Vibrio Infections	0	1	1	2	**4**	0	0	0	0	**0**
West Nile Virus	0	0	7	1	**8**	0	0	2	8	**10**
Yersiniosis	1	2	0	4	**7**	3	2	0	5	**10**

* Due to the new law requiring HIV reporting by name that started in April 2006, HIV case counts have started over. Previously reported cases are no longer valid.

MRSA Infections, Continued

marily treated with incision and drainage (I&D). Not only is I&D alone curative in many cases, but drainage allows for antibiotic susceptibility testing. This is useful for both patient management if I&D alone is not curative, and improved understanding of local resistance patterns. Indications for ancillary antibiotic therapy in addition to I&D, or when drainage is not possible include: presence of systemic symptoms (e.g., fever, chills, dyspnea), cellulitis or worsening local symptoms (e.g., spreading SSTI, fasciitis), immunosuppression (including HIV), extremes of age, or symptoms refractory to initial management. Depending on local epidemiology, empiric oral antibiotic therapy for less severe infections may include trimethoprim-sulfamethoxazole (TMP-SMX), and a tetracycline or clindamycin; linezolid is a comparatively expensive option.

Key Management Considerations and Steps:

- Antibiotic susceptibility patterns of *S. aureus* infections are not distinguishable clinically.
- Incise and drain abscesses as first-line management whenever possible.
- Send one or more drainage specimens for bacterial culture and sensitivity testing. Note: culturing the nares or skin is not helpful as results may not reflect the bacteriology of the underlying infection.
- When antimicrobial therapy is indicated in infected patients and where local hospital antibiograms reflect substantial prevalence of CA-MRSA, initial therapy should be directed against MRSA.
- Beta-lactams (penicillins/ cephalosporins) should not be prescribed when MRSA is a possible etiology.
- Educate patients on proper wound care and prevention of transmission to close contacts (see below).
- Exercise standard precautions in clinical settings to avoid transmission of MRSA.
- Widespread screening for nasal colonization is not recommended.

Patient Education

Recent studies reinforce the importance of educating patients about standard precautions, which include practical steps that may reduce the risk of acquiring CA-MRSA. The following are general risk reduction steps clinicians should convey to patients who are concerned about CA-MRSA, as well as patients with previous MRSA infections.

- Proper and frequent hand hygiene (washing with soap and water or using alcohol-based hand sanitizer) to eliminate bacteria on skin surfaces.
- Keep skin clean and bathe with soap; it is unknown if antibacterial soaps offer additional benefit.
- Keep skin moist with lotion to avoid damaged skin that may become dry and cracked.
- Avoid shaving in moist body areas or areas that have been previously infected and/or ensure that shaved skin remains clean and dry.
- Keep skin cuts and scrapes clean and covered with a bandage until healed; antibiotic containing ointments (i.e., bacitracin) are acceptable.
- Avoid direct contact with other people's wounds or bandages; wash hands thoroughly with soap after any such contact.
- Avoid sharing personal hygiene items such as towels or razors.
- In a gym, steam room, or locker room use a clean towel when sitting on benches.
- Use a disinfectant on gym equipment before and after use.
- There is no evidence toilet seats are associated with transmission of *S. aureus*.
- With sexual contact:
  Avoid contact with an area of another person's skin that is known to be infected. Shower and/or clean the skin after sex. Research shows reducing the number of sex partners helps lower the risk of getting other STDs, including HIV. It may help reduce the risk of contracting MRSA by decreasing the amount of exposure to skin of others who might be infected.

Reporting

Individual cases of severe *S. aureus* infections (see article below) including MRSA, as well as outbreaks due to MRSA, should be reported to the San Joaquin County Public Health Services Communicable Disease Program by telephone at (209) 468-3822 or by fax at (209) 468-8222.

For more information visit the links below:

Diep, et al: http://www.annals.org/cgi/content/full/0000605-200802190-00204v1

California Department of Public Health: http://www.cdph.ca.gov/HealthInfo/discond/Pages/MRSA.aspx

San Francisco Department of Public Health: http://www.sfcdcp.org/index.cfm?id=100

Severe *Staphylococcus aureus* Infections Now Reportable by Healthcare Providers

Effective February 13, 2008, a severe *Staphylococcus aureus* infection in a previously healthy person resulting in death or admission to an intensive care unit is reportable by healthcare providers to local health departments (LHDs). A previously healthy person is defined as one who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture. **Infection with either methicillin-sensitive or methicillin-resistant *S. aureus*** (MSSA or MRSA) is reportable if the patient fits the case definition. A case of toxic shock syndrome due to *S. aureus* should continue to be reported under toxic shock syndrome and not under this new case category.

Public health surveillance for these severe *S. aureus* cases will help identify the types of community-associated *S. aureus* infections, including MRSA infections, that are the most concerning. Examples of severe illness syndromes caused by *S. aureus* include invasive skin and soft-tissue infection, necrotizing fasciitis, musculoskeletal infection (pyomyositis, osteomyelitis), severe pneumonia, empyema, necrotizing pneumonia, disseminated infections with septic emboli, bactere-

(Continued on page 6)

San Joaquin County AIDS Statistics

The following data are based on the 1166 AIDS cases reported to San Joaquin County Public Health Services from 1983 through December 31, 2007.
Of these 1166 cases:

- 1150 were in adults/adolescents (age ≥ 13 at time of diagnosis); 982 male (85.4%) and 168 female (14.6%)
- 16 of the cases were classified as pediatric (age <13 at time of diagnosis); 6 male (37.5%) and 10 female (62.5%). Eleven (68.8%) were exposed from a mother with/at risk for HIV, and 5 (31.3%) had blood exposure
- 578 deaths occurred among these cases, for a case-fatality rate of 49.6%

Note: In the following tables, data are displayed for cumulative AIDS cases through 4th quarter 2007

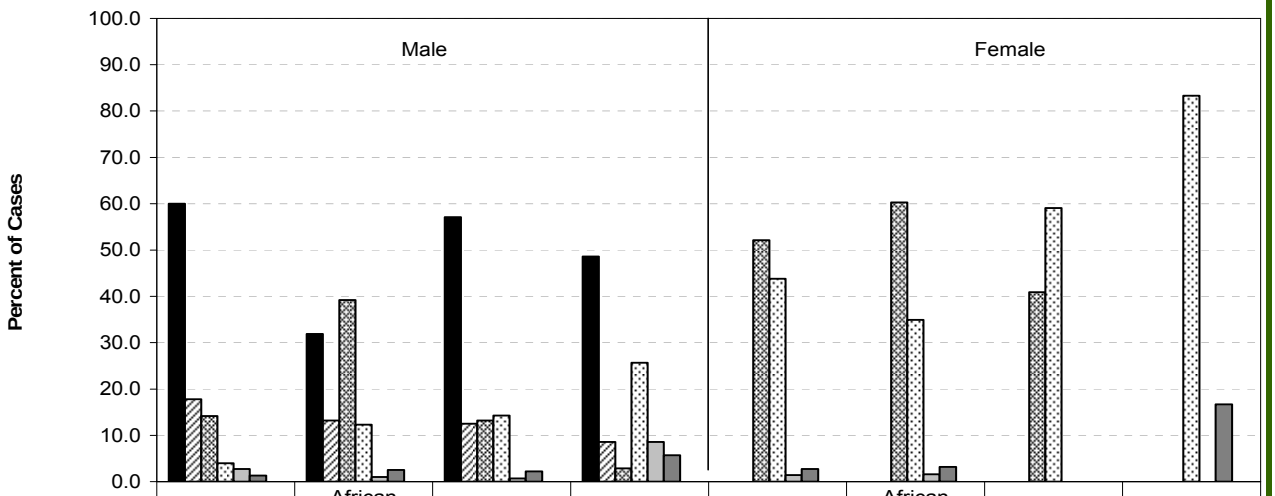
	1983 – 12/31/07	
AGE GROUP[1]	# OF CASES	% OF CASES
UNDER 5	10	0.9%
5-12	6	0.5%
13-19	8	0.7%
20-29	181	15.5%
30-39	492	42.2%
40-49	306	26.2%
Over 49	163	14.0%
TOTAL	1166	100%

[1]Age at diagnosis

	1983 – 12/31/07	
RACE/ ETHNICITY	# OF CASES	% OF CASES
White	530	45.5%
African-American	271	23.2%
Hispanic	298	25.6%
Asian/P.I.[1]	42	3.6%
A.I./A.N.[2]	4	0.3%
Multi-race	19	1.6%
Unknown	2	0.2%
TOTAL	1166	100%

[1]P.I. = Pacific Islander
[2]A.I./A.N. = American Indian/Alaska Native

Cumulative Adult AIDS Cases by Exposure Category, Gender, and Race/Ethnicity, San Joaquin County, 1983-2007 (N=1150)



	White	African American	Hispanic	Asian/PI	White	African American	Hispanic	Asian/PI
MSM	60.0	31.9	57.1	48.6	N/A	N/A	N/A	N/A
MSM & IDU	17.8	13.2	12.5	8.6	N/A	N/A	N/A	N/A
IDU	14.2	39.2	13.2	2.9	52.1	60.3	40.9	0.0
Heterosexual Contact	4.0	12.3	14.3	25.7	43.8	34.9	59.1	83.3
Blood Exposure	2.7	1.0	0.7	8.6	1.4	1.6	0.0	0.0
Risk Not Reported/Other	1.3	2.5	2.2	5.7	2.7	3.2	0.0	16.7
Total Number of Cases	450	204	273	35	73	63	22	6

San Joaquin County HIV Statistics

Of the 297 HIV name-based cases reported to San Joaquin County Public Health Services from April 17, 2006 through December 31, 2007:

- 293 of the cases were in adults/adolescents (age ≥ 13 at time of diagnosis); 230 male (78.5%) and 63 female (21.5%)
- 4 of the cases were classified as pediatric (age <13 at time of diagnosis); all are male

Note: In the following tables and figures, data are displayed for name-based, cumulative HIV cases reported through 4th quarter 2007

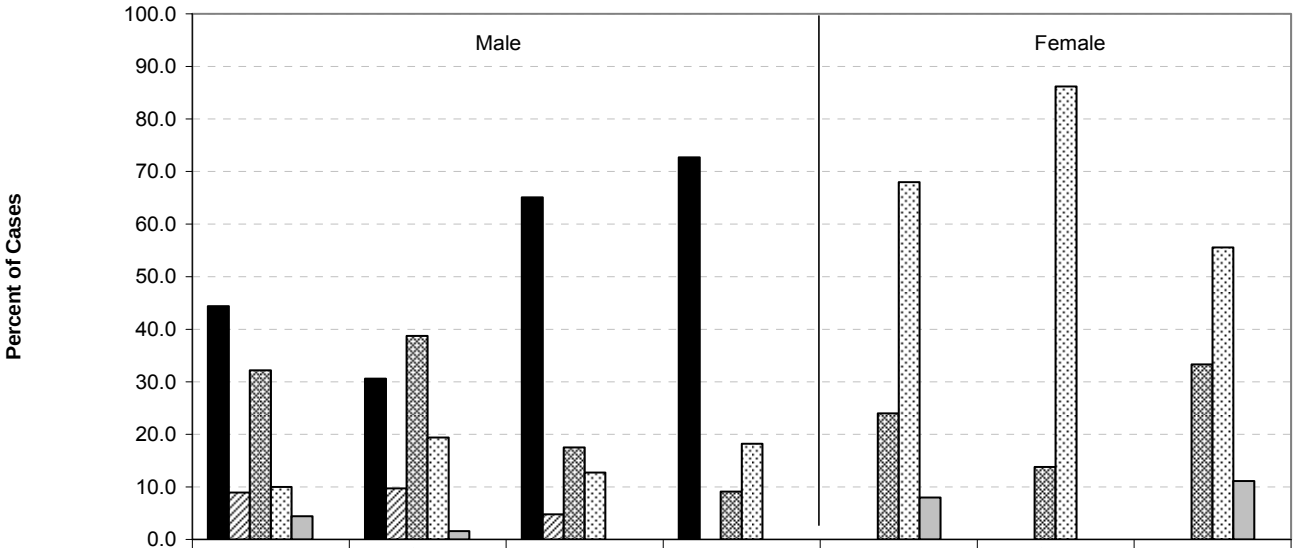
	4/17/06 – 12/31/07	
AGE GROUP[1]	**# OF CASES**	**% OF CASES**
Under 5	3	1.0%
5-12	1	0.3%
13-19	9	3.0%
20-29	88	29.6%
30-39	98	33.0%
40-49	75	25.3%
Over 49	23	7.7%
TOTAL	**297**	**100%**

[1]Age at diagnosis

	4/17/06– 12/31/07	
RACE/ ETHNICITY	**# OF CASES**	**% OF CASES**
White	117	39.4%
African-American	93	31.3%
Hispanic	72	24.2%
Asian/P.I.[1]	11	3.7%
A.I./A.N.[2]	2	0.7%
Multi-race	2	0.7%
Unknown	0	0.0%
TOTAL	**297**	**100%**

[1]P.I. = Pacific Islander
[2]A.I./A.N. = American Indian/Alaska Native

Name-Based Adult HIV Cases by Exposure Category, Gender, and Race/Ethnicity, San Joaquin County, 5/17/2006-12/31/2007 (N=293)



	White	African American	Hispanic	Asian/PI	White	African American	Hispanic
MSM	44.4	30.6	65.1	72.7	N/A	N/A	N/A
MSM & IDU	8.9	9.7	4.8	0.0	N/A	N/A	N/A
IDU	32.2	38.7	17.5	9.1	24.0	13.8	33.3
Heterosexual Contact	10.0	19.4	12.7	18.2	68.0	86.2	55.6
Risk Not Reported/Other	4.4	1.6	0.0	0.0	8.0	0.0	11.1
Total Number of Cases	90	62	63	11	25	29	9

Severe *S. aureus* Infections Reportable, Continued

mia, and sepsis. Surveillance data can help to identify populations at risk for severe community-associated *S. aureus* infections, and provide additional information that can be used to plan prevention and control measures.

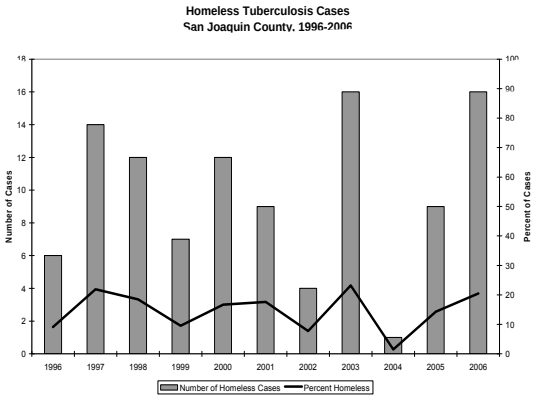
If a case of severe *S. aureus* infection in a previously healthy person fitting the surveillance case definition is identified, healthcare providers should notify the local health department of the case and send in a filled out Confidential Morbidity Report (CMR) form. The local health departments will also fill out a separate case report form and may need to follow up with local healthcare providers for additional information.

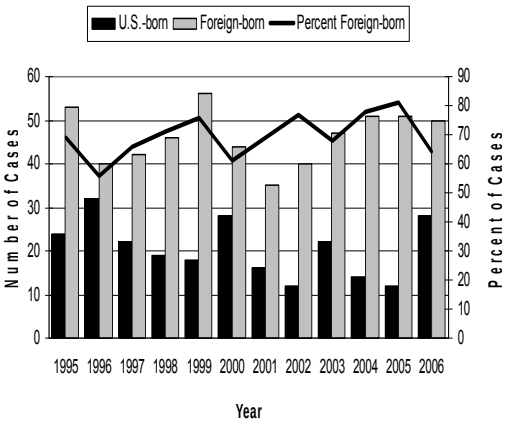
California Department of Public Health information on MRSA and links to other sources of information are provided at http://www.cdph.ca.gov/HealthInfo/discond/Pages/MRSA.aspx.

If you diagnose or suspect a case of severe *Staphylococcus aureus* infection notify San Joaquin County Public Health Services Communicable Disease Program by telephone at (209) 468-3822 or by fax at (209) 468-8222.

Tuberculosis Outbreak among the Homeless, San Joaquin County

During 2006, San Joaquin County saw a 23.8% increase in tuberculosis (TB) cases. This prompted further investigation by SJC PHS Epidemiologists into the cause of the rise in cases. Demographic data indicated an increase in homeless cases compared to the previous 2 years, as well as an increase in U.S.-born cases (see graphs below).





Genotyping (DNA fingerprinting that is done by the California Department of Public Health to identify similar TB strains) data identified a cluster (CA_384) of 13 cases that first appeared in October 2006. The cases were then linked to their demographic data, and it was determined that 12 of these 13 cases were homeless males and 9 of the 13 were U.S.-born. The one exception to the homeless cases was a known contact to a homeless male. All 12 of the homeless male cases were found in the intake database of Shelter A, and some were also found on the intake lists for Shelter B.

In order to identify additional cases associated with the outbreak, a case definition was developed. A **confirmed** case was defined as: 1) any TB case whose genotyping results matched the CA_384 strain, **or** 2) any TB case whose genotype results closely matched CA_384 that had one of the following characteristics: a) contact to another confirmed outbreak case, b) homeless or marginally housed in San Joaquin County any time since 1/1/2005, or c) spent time in Shelter A beginning in January 2005. A **probable** case was defined as any TB case without genotyping results that had one of the following characteristics: 1) spent time in Shelter A on or after January 1, 2005, **or** 2) was a contact to a confirmed outbreak case.

In August 2007 state and local public health investigators began re-interviewing outbreak cases to identify any other possible contacts or locations of transmission. Infectious periods were established for the outbreak cases and compared against the time the cases spent in the shelter to help identify contacts to the cases that had a higher risk for acquiring TB.

In October 2007, Public Health began an intensive effort to screen individuals for TB at Shelter A and Shelter B. The screening included symptom review and chest x-ray. During October 2-17, 2007 over 300 persons were screened and 1 previously unknown case was identified.

As of October 7, 2008 35 confirmed and 10 probable cases had been identified. All but 9 of the 35 confirmed cases were reported in San Joaquin County; 3 were reported by other states, and six were reported by other counties in California. Of the 26 confirmed in San Joaquin County, 25 (96%) are male, 14 (54%) are Hispanic, 6 (23%) are white, 5 (19%) are black, and 1 (4%) is Asian.

Currently Public Health has an ongoing shelter screening program. It consists of screening males staying at Shelter A or Shelter B using symptom review and a QuantiFERON test (see page 7 for more information on this test). For entrance into the shelters, the program now requires a shelter clearance card available only through San Joaquin County Public Health Services.

If you suspect a case of TB please notify the San Joaquin County Public Health Services Tuberculosis Control Program within 1 working day by telephone at (209) 468-3828 or by fax at (209) 468-8222.

QuantiFERON-TB Gold Blood Test for TB Infection

What is it?

The QuantiFERON-TB Gold test (QFT) is a whole-blood test for detection of infection with *Mycobacterium tuberculosis*, as occurs in active tuberculosis (TB) and latent tuberculosis infection (LTBI). If not detected and treated, LTBI may later develop into TB disease.

The QFT measures the patient's immune reactivity to *M. tuberculosis*, the bacterium that causes TB. This test was approved by the U.S. Food and Drug Administration (FDA) in 2004.

While QFT has been approved for use in all patients, published data are limited in persons with impaired immune function and recent TB exposure.

How does it work?

Blood samples are mixed with antigens and incubated for 16 to 24 hours. The antigens include ESAT-6 and CFP-10, proteins specific to the *M. tuberculosis complex*. These antigens are not found in BCG vaccine strains or *Mycobacterium avium*. If the patient is infected with *M. tuberculosis*, the patient's lymphocytes will recognize the antigens and release interferon-gamma (IFN-g) in response. The QFT results are based on the amount of IFN-g that is released.

Additional tests (such as chest radiograph) are needed to exclude TB disease and confirm the diagnosis of LTBI. **Like the TB Skin Test (TST), the QFT is a useful but imperfect diagnostic aide. It should not replace clinical judgment.**

What are the advantages?

- More likely to be positive with active TB disease than the TST (*more sensitive*).
- Less likely to be positive in patients with past exposure to BCG or atypical mycobacterium and no TB risk factors (*more specific*).
- Only needs a single patient visit - does not require return visit to determine results.
- Does not cause the booster phenomenon, which can happen with repeat tuberculin skin tests (TST).
- Is less subject to reader bias and error when compared to the TST.
- Results are not known to be affected by a past TST.

What are the disadvantages?

- As with the TST, additional tests are needed to exclude TB disease and confirm LTBI.
- Blood samples must be processed within 12 hours of blood draw.
- In San Joaquin County the test is currently only available through the Public Health Laboratory.

When should you use the QFT?

QFT can be used for anyone who needs testing for tuberculosis. High-risk populations to test include:

- Individuals with medical risk factors for TB reactivation (e.g. diabetes, chronic renal failure, silicosis, malnutrition)
- Newcomers (<5 years) to the U.S. from TB endemic areas (all ages)
- Homeless individuals
- Injection drug users
- Patients with an abnormal CXR consistent with old or active TB
- Residents of high-risk congregate settings (shelters, nursing homes, jails, substance abuse treatment facilities)
- Organ transplant patients (before transplant)

When to use both QFT *and* TST?

When the risk of TB is highest, and the maximum sensitivity for detection of M. tuberculosis infection is needed, a dual-testing strategy is preferred if possible, such as for:

- Persons with clinical suspicion of active tuberculosis, as a diagnostic aide to radiographic and clinical evaluation.
- Immunocompromised individuals (HIV+ persons or those receiving immunosuppressive medications, including TNF-alpha antagonists)

What are the steps in administering the QFT test?

- Call the Public Health Lab in advance of drawing the blood to arrange for pick up or delivery at (209) 468-3460.
- Draw a ≥5 cc sample of whole blood from the patient into a tube with an anti-clotting agent (lithium heparin tube) and mix well.
- Deliver processed blood to San Joaquin County Public Health Laboratory, Monday through Thursday by 3:30 PM. Must be delivered within 12 hours of collection.
- Schedule an appointment for the patient to receive test results; those with positive results require a CXR, medical evaluation and consideration of treatment for LTBI.

How do you interpret test results?

Negative: Same interpretation as negative TST – no further TB evaluation unless indicated by clinical judgment.
Positive: Same interpretation as positive TST. Radiograph and medical evaluation indicated.
Indeterminate: Test failure. Administer TST as diagnostic aide for TB or LTBI.

Who can order a QFT?

In San Joaquin County, the QFT test is currently only being used for select populations. For other patients and special circumstances QFT testing may be requested by calling the Public Health Laboratory at (209) 468-3460 or the TB Control Program at (209) 468-3828.

Additional Information:

CDC. Guidelines for using the QuantiFERON®-TB Gold for detecting M. tuberculosis infection. MMWR CDC. Guidelines for using the QuantiFERON®-TB Gold for detecting M. tuberculosis infection. MMWR, December 16, 2005 / 54(RR15); 49-55

Pai M, et al. Interferon-g assays in the immunodiagnosis of tuberculosis: a systematic review. *Lancet Infect Dis.* 2004;4:761-76

WHO TO REPORT TO:

For all diseases *except* HIV/AIDS and Sexually Transmitted Diseases

Phone: (209) 468-3822, or
Fax: (209) 468-8222, or
Mail: San Joaquin County Public Health Services
Attention: Morbidity
P.O. Box 2009
Stockton, CA 95201-2009

For Sexually Transmitted Diseases

Phone: (209) 468-3862, or
Fax: (209) 948-7473, or
Mail: (Seal and mark: CONFIDENTIAL)
San Joaquin County Public Health Services
Attention: Sexually Transmitted Diseases
P.O. Box 2009
Stockton, CA 95201-2009

For HIV/AIDS Reports

Phone: (209) 468-3475, or
Fax: (no fax)
Mail: (Seal and mark: CONFIDENTIAL)
San Joaquin County Public Health Services
Attention: Rosa Castillo-Cuellar
P.O. Box 2009
Stockton, CA 95201-2009

Visit Public Health on the web:
http://www.sjgov.org/phs/

For address or recipient information changes please contact: Karen Pfister at 468-9841

A copy of this report can be found on the Epidemiology page of the Public Health Services website. The web address is: http://www.sjcphs.org/Disease/Epidemiology.htm

SAN JOAQUIN COUNTY
PUBLIC HEALTH SERVICES
P.O. BOX 2009
(1601 E. HAZELTON AVE)
STOCKTON, CA 95201-2009

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