



**Communicable Disease
Surveillance Centre
(Northern Ireland)**

**HIV and STI
Surveillance in
Northern Ireland: 2006**

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This report aims to provide an overview of HIV and STI epidemiology in Northern Ireland by collating and analysing information from a number of sources of routinely collected data. Building on the template of last year's report it will reflect epidemiological trends over time, but its main focus will be on data collected in 2005.

Comments on the content and format of this report would be particularly welcome and may be addressed to cdscni@hpa.org.uk

Summary Points

- ❖ 63 new first-UK HIV diagnoses were made in Northern Ireland during 2005, the highest annual total since reporting began
- ❖ 285 HIV-infected residents of Northern Ireland (as defined when last seen for care in 2005) received HIV-related care during 2005, an increase of 19% on 2004 (239)
- ❖ 38 new diagnoses of infectious syphilis were reported in 2005, a decrease of 39% on 2004 (62) (Enhanced Syphilis Surveillance System)

In Northern Ireland GUM clinics in 2005:

- ❖ Total diagnoses increased by 12%; 12,847 in 2005 compared with 11,507 in 2004
- ❖ New diagnoses of uncomplicated chlamydia increased by 12%; 1,631 in 2005 compared with 1,453 in 2004
- ❖ New diagnoses of genital warts (first attack) increased by 10%; 2,306 in 2005 compared with 2,101 in 2004
- ❖ New diagnoses of genital herpes simplex (first attack) increased by 7%; 238 in 2005 compared with 222 in 2004
- ❖ New diagnoses of uncomplicated gonorrhoea increased by 47%; 182 in 2005 compared with 124 in 2004

Surveillance arrangements and sources of data

HIV

Surveillance arrangements for diagnosed HIV/AIDS infection for England, Wales and Northern Ireland are based largely on the confidential reporting of HIV infected individuals to the Health Protection Agency's Centre for Infections in London. There are two main outputs:

- ❖ Data relating to individuals whose first UK diagnosis was made in Northern Ireland, published as quarterly updated tables

www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/epidemiology/hars_tables.htm

- ❖ Data relating to individuals who accessed UK-based statutory HIV services, published as annual reports of the Survey of Prevalent HIV Infected cases (SOPHID)

www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/sophid/sophid_main.htm

KC60 returns

The most comprehensive source of surveillance data for sexually transmitted infections in Northern Ireland is provided by the statutory KC60 return made each quarter from GUM clinics. Using the same format as in England and Wales, this records the numbers of new diagnoses for a range of STIs. For selected conditions, additional age, gender and sexual orientation information is provided. Regularly updated summary statistics are presented at www.cdscni.org.uk.

There are two important limitations to KC60 data, however. Firstly, as data reflect only those diagnoses made in GUM clinics it follows that accessibility of those services to the public as measured by service capacity and the geographic location of services may influence the diagnostic rate of STIs. Thus direct comparison of different regions (which may have different levels of GUM service provision) must be interpreted with caution.

Secondly, unlike HIV surveillance arrangements, no residence-based data are collected. Given that the majority of new diagnoses originate from the largest and most accessible clinic at the Royal Group of Hospitals Trust site, clinic location is not a useful proxy for patient residence.

Enhanced syphilis surveillance

Enhanced surveillance arrangements for the ongoing syphilis outbreak in Northern Ireland have been in place since the outbreak was first recognised in September 2001. Based on anonymised, confidential reporting by clinicians to CDSC (NI), a range of demographic, clinical and risk factor data are collected. Analysis is fed back to the outbreak control team in the form of regular epidemiological reports.

1: HIV

HIV/AIDS is a viral infection caused by type 1 and type 2 HIV retroviruses. Modes of transmission include sexual contact, the sharing of HIV contaminated needles and syringes, and transmission from mother to child before, during or shortly after birth. Although the risk of HIV transmission through sexual contact is lower than for most other sexually transmitted agents, this is increased in the presence of another sexually transmitted illness, particularly where ulcerative. Early treatment of the disease with highly active antiretroviral therapy (HAART) has made major advances in survival rates.

While prevalence in Northern Ireland remains lower than the other UK countries, annual new diagnoses have increased year on year since 2001, almost doubling between 2003 and 2004. The key routes of transmission remain sexual contact between men who have sex with men (MSM) and sexual contact between men and women.

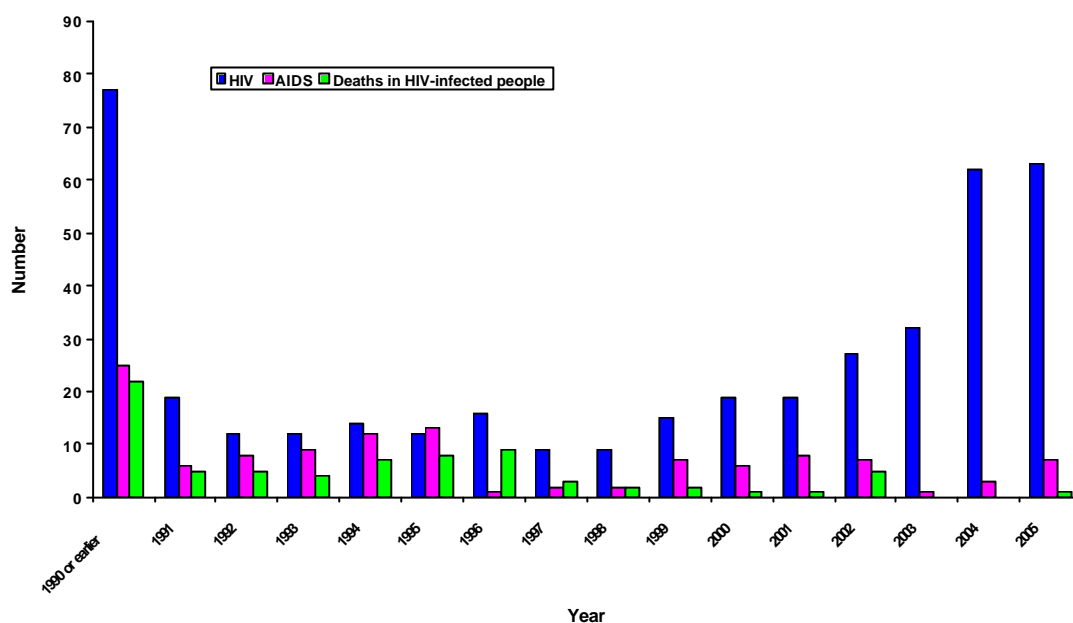
During 2005:

- ❖ 63 new first – UK cases of HIV were diagnosed in Northern Ireland. Seven of these presented with AIDS
- ❖ 22 diagnoses were made in MSM, with 17 in heterosexual males, and 21 in heterosexual females
- ❖ 2 cases were reported in IDUs
- ❖ 69% (24/35) cases acquired through heterosexual contact were acquired abroad, with 31% (11/35) acquired through exposure in the UK
- ❖ 285 HIV-infected residents of Northern Ireland (as defined when last seen for care in 2005) received care
- ❖ 43% (122/285) of those receiving care have been diagnosed with AIDS
- ❖ Of those receiving care, 48% (136/285) acquired their infection through sexual contact between MSM and 45% (129/285) through heterosexual contact

Trend Information

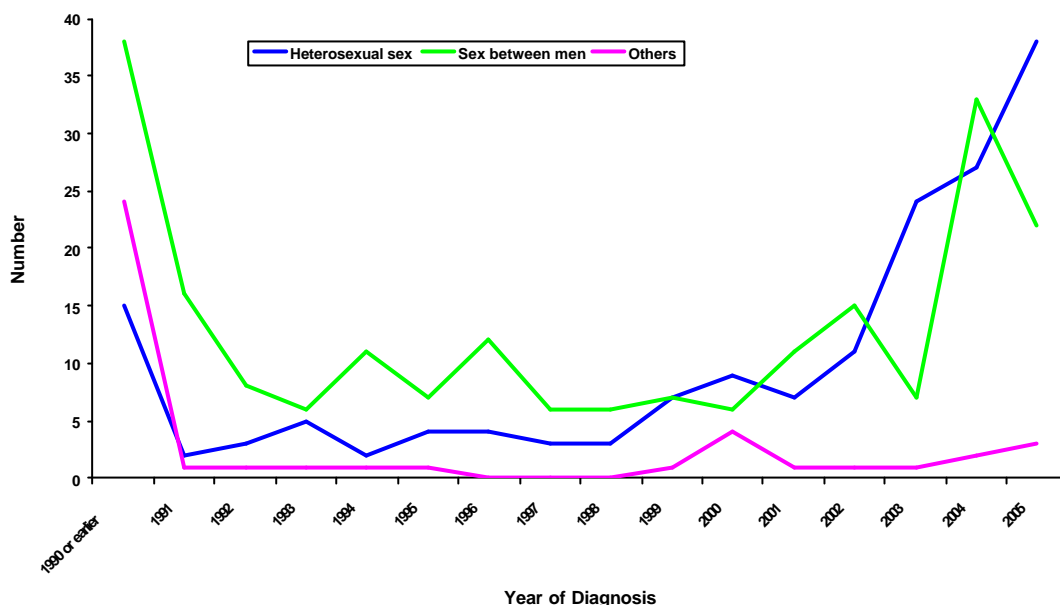
2005 saw a continuation of the year on year increase in annual diagnoses of new cases since 2001 (Figure 1.1). The annual numbers of new AIDS diagnoses and deaths continue to remain low, due largely to the influence of HAART.

Figure 1.1: HIV and AIDS diagnoses and deaths in HIV-infected individuals, by year to end 2005, Northern Ireland



Analysis of trends of the probable route of exposure is complicated by the small number of cases in each category and the potential for year to year variation (Figure 1.2). While new diagnoses continue to be made among MSM, heterosexual transmission has assumed increasing importance and now accounts for 39% (164/417) of all cases diagnosed in Northern Ireland since reporting began. Cumulative data also show that, as elsewhere in the UK, the majority of those infected through heterosexual contact with non-“high risk” partners have been infected through exposure outside the UK (74%;113/153), with 62% (70/113) of these reporting exposure in Africa. During this time 26% (40/153) of those infected through heterosexual contact have acquired their infection from exposure within the UK.

Figure 1.2: Exposure category of HIV-infected individuals by year of diagnosis, Northern Ireland



The numbers of HIV-infected residents of Northern Ireland (as defined when last seen for care in 2005) receiving care have increased to 285 in 2005, compared with 104 in 2000 (Table 1.1). This reflects both the continued increase in new diagnoses being made, and the role of HAART in increasing survival of those infected with HIV.

Table 1.1: Numbers of HIV-infected patients by route of infection, resident in Northern Ireland when last seen for care

	MSM	IDU	Heterosexual men and women	Mother to infant †	Other/not reported	Total
2000	61	4	35	1	3	104
2001	74	4	45	2	3	128
2002	82	5	52	1	3	143
2003	96	5	78	5	5	189
2004	124	5	99	8	3	239
2005	136	7	129	9	4	285

† Mother to infant transmission includes children born to HIV infected women in that year, whose HIV infection status has not been confirmed. At least 95% of these children are likely to be uninfected. During 2005, there were 4 such children.

2: Syphilis

Syphilis is a bacterial infection caused by the spirochete *Treponema pallidum*. Its importance lies in its ability to promote both the acquisition and transmission of HIV, and in the potential for serious or even fatal consequences of syphilis itself for the infected individual if left untreated. Late syphilis can cause complications of the cardiovascular, central nervous and mucocutaneous systems. Infectious syphilis in pregnant women can cause miscarriage, stillbirth or congenital infection.

Northern Ireland has, in common with elsewhere in UK and Europe, experienced a marked increase in infectious syphilis since 2001. In the preceding decade, on average only one case of infectious syphilis per year was reported.

During 2005:

- ❖ 38 episodes representing 38 individuals were diagnosed
- ❖ 12 presented as primary syphilis, 11 as secondary and 7 as early latent syphilis. For 8 episodes the stage of illness was not known
- ❖ 25 episodes were diagnosed in MSM, 5 in heterosexual men and 8 in women
- ❖ All 38 episodes occurred in residents of Northern Ireland, and 26 are likely to have acquired syphilis through exposure within Northern Ireland
- ❖ The highest new diagnostic rate was in EHSSB residents (3.75/100,000 population), followed by SHSSB (2.14/100,000), WHSSB (0.69/100,000) and finally NHSSB (0.68/100,000)
- ❖ Diagnosed co-infections included chlamydia (4), gonorrhoea (2), non-specific urethritis (2) and hepatitis C (1)
- ❖ 47% (18/38) reported one sexual partner in the three months preceding diagnosis. The highest number of sexual partners reported in this time was 13

Trend information

During 2005, 38 cases were diagnosed representing a 39% decrease on the 2004 figure (62). The outbreak continues to involve predominantly MSM, with 26% (50/189) of diagnoses to end 2005 made in heterosexual men and women (Table 2.1).

Table 2.1: Gender and sexual orientation of episodes of infectious syphilis, by year of diagnosis, 2001-2005

	Homosexual Male	Heterosexual Male	Bisexual Male	Heterosexual Female	Total
2001	16 (73%)	2 (9%)	1 (5%)	3 (13%)	22
2002	25 (83%)	3(10%)	1 (3%)	1 (3%)	30
2003	26 (70%)	7 (19%)	1 (3%)	3 (8%)	37
2004	38 (61%)	11 (18%)	6 (10%)	7 (11%)	62
2005	22 (58%)	5 (13%)	3 (8%)	8 (21%)	38
Total	127	28	12	22	189

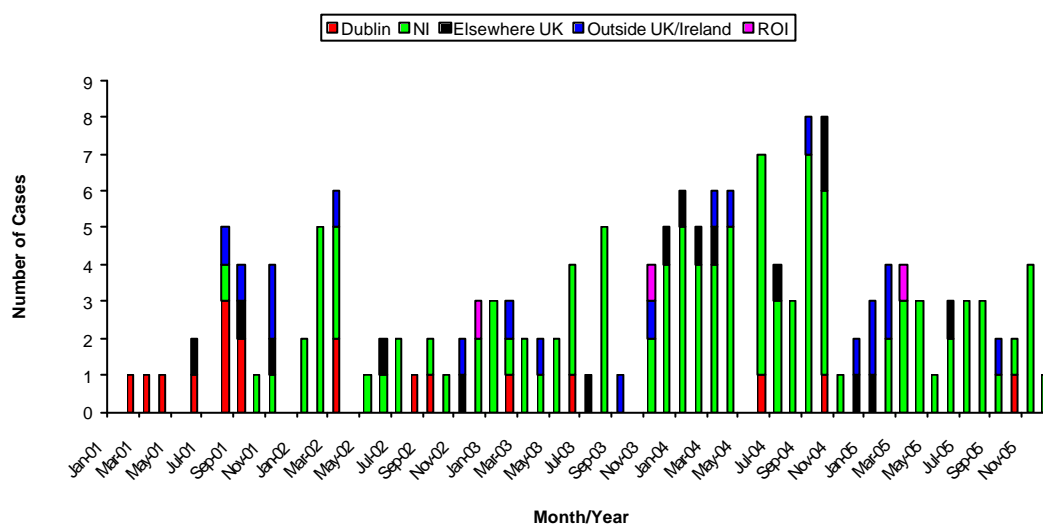
There has been little variation in the stage of disease at which diagnosis is made, with primary and secondary stages accounting for 69% (131/189) of diagnoses to end 2005. Primary stage disease accounts for 37% (70/189), secondary stage for 32% (61/189) and early latent for 15% (28/189) of diagnoses (Table 2.2).

Table 2.2: Stage of disease by year of diagnosis(n=189)

	Primary	Secondary	Early Latent	Unknown
2001	10	4	4	4
2002	13	9	6	2
2003	15	10	7	5
2004	20	27	4	11
2005	12	11	7	8

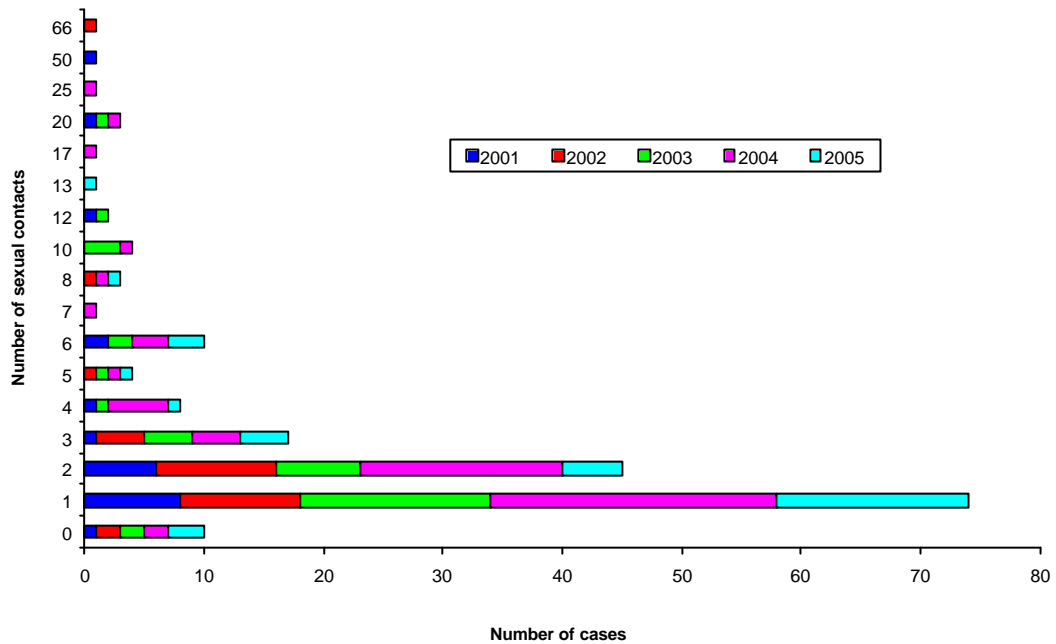
While initial episodes were linked to an outbreak among MSM in Dublin, the majority of episodes in both MSM and heterosexuals have been acquired in Northern Ireland (Figure 2.1).

Figure 2.1: Trends in location of acquisition of syphilis infection, by month of diagnosis, 2001-2005 (n=168)

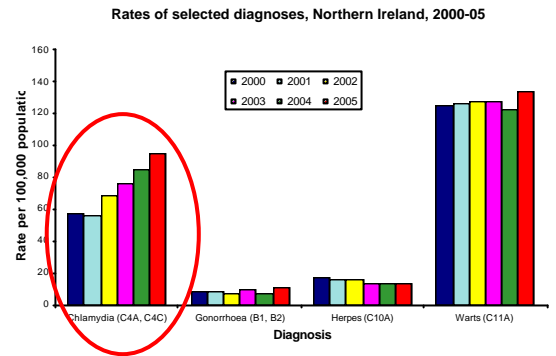


Mathematical modelling of the transmission of sexually transmitted infections has shown how those individuals with high rates of partner change play a disproportionately large role in the spread of infection. While the majority of cases in this outbreak report one or two partners, in the three months prior to diagnosis some report larger numbers (Figure 2.2).

Figure 2.2: Number of sexual contacts in the three months prior to diagnosis, by year of diagnosis (n=186)



Actions taken by the Outbreak Control Team to date have included outreach testing programmes and publicity within both the general and MSM communities. Syphilis will be the main focus of a sexual health promotion website to be developed around the sexual health of MSM.



3: Chlamydia

Genital chlamydia is a bacterial infection caused by *Chlamydia trachomatis*. The infection is asymptomatic in at least 50% of men and 70% of women. In women, untreated infection can cause chronic pelvic pain and lead to pelvic inflammatory disease (PID), ectopic pregnancy and infertility. An infected pregnant woman may also pass the infection to her baby during delivery. Complications in men include urethritis, epididymitis and Reiter's Syndrome.

As elsewhere in the UK, chlamydia is the most common bacterial STI diagnosed in GUM in Northern Ireland. While diagnostic rates are lower than other parts of the UK there has been a similar rate of increase here from 2000 to 2005.

During 2005:

Uncomplicated chlamydial infection:

- ❖ There were 1,631 new episodes of uncomplicated chlamydial infection diagnosed at GUM clinics in Northern Ireland, compared to 1,453 in 2004 (Table 3.1)
- ❖ 848 (52%) of these were diagnosed in women and 783 (48%) in men
- ❖ The highest rates of infection in both men and women were diagnosed in the 20-24 years age group
- ❖ 47% of female diagnoses and 43% of male diagnoses were in the 20-24 years age group
- ❖ The rate of diagnoses in the 16-19 years age group is three times higher in females than males
- ❖ 7% (52/783) of the total male diagnoses were attributed to men who have sex with men (MSM)

Complicated chlamydial infection:

- ❖ There were 82 new episodes of complicated chlamydial infection diagnosed at GUM clinics in Northern Ireland
- ❖ 62 (76%) of these were diagnosed in women and 20 (24%) in men

Table 3.1: Diagnoses and age specific rates of uncomplicated chlamydia, 2004-2005, Northern Ireland

		2004			2005			% increase/decrease		
		M	F	Total	M	F	Total	M	F	Total
Numbers of diagnoses	<16	0	13	13	0	9	9	-	-31	-31
	16-19	72	206	278	75	215	290	4	4	4
	20-24	326	333	659	334	396	730	2	19	11
	25-34	247	159	406	303	184	487	23	16	20
	35-44	46	32	78	54	38	92	17	19	18
	45+	12	7	19	17	6	23	42	-14	21
Total		703	750	1,453	783	848	1,631	11	13	12
Age-specific rate per 100,000 population	<16	0	34	17	0	24	12	-	-29	-29
	16-19	131	398	261	137	417	273	5	5	5
	20-24	549	583	566	541	669	604	-1	15	7
	25-34	219	137	178	268	160	213	22	17	20
	35-44	37	25	31	43	29	36	16	16	16
	45+	4	2	3	6	2	4	50	-	33
Total		84	86	85	93	96	95	11	12	12

Trends: 2000-2005

Between 2001 and 2005, total diagnoses of uncomplicated chlamydial infection have increased by 72%, from 947 diagnoses in 2001 to 1,631 in 2005. Diagnoses in males have increased by 66% while in females there has been a 79% increase. Diagnoses of complicated chlamydial infection have remained low (Figure 3.1).

Figure 3.1: Diagnoses of chlamydia, Northern Ireland, 2000-2005

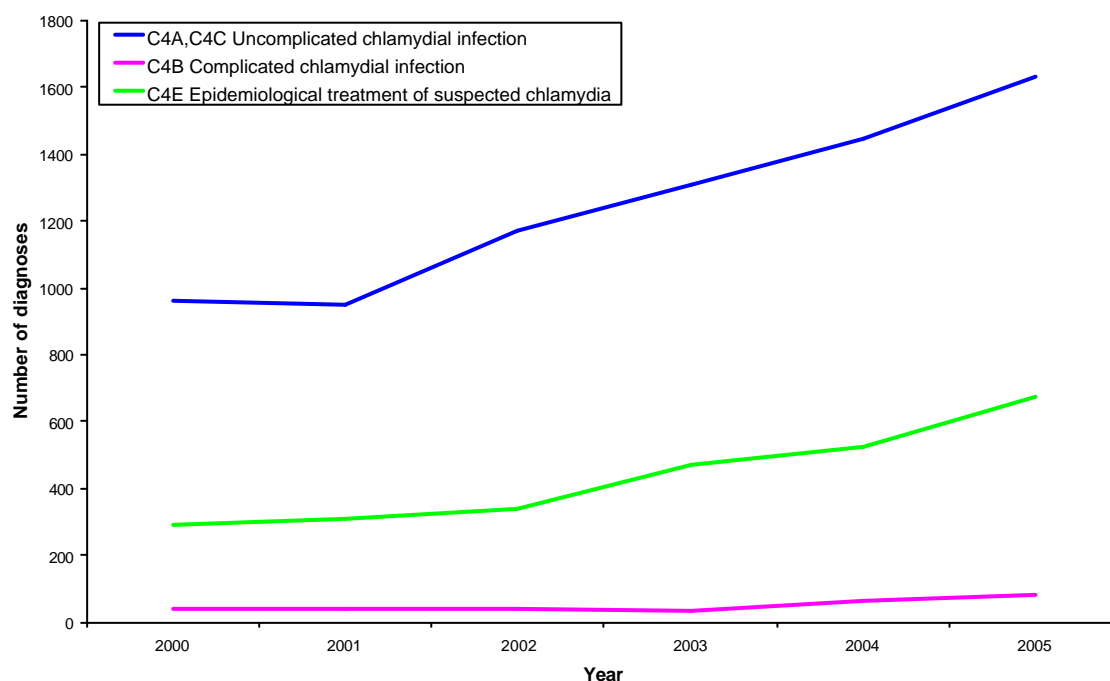
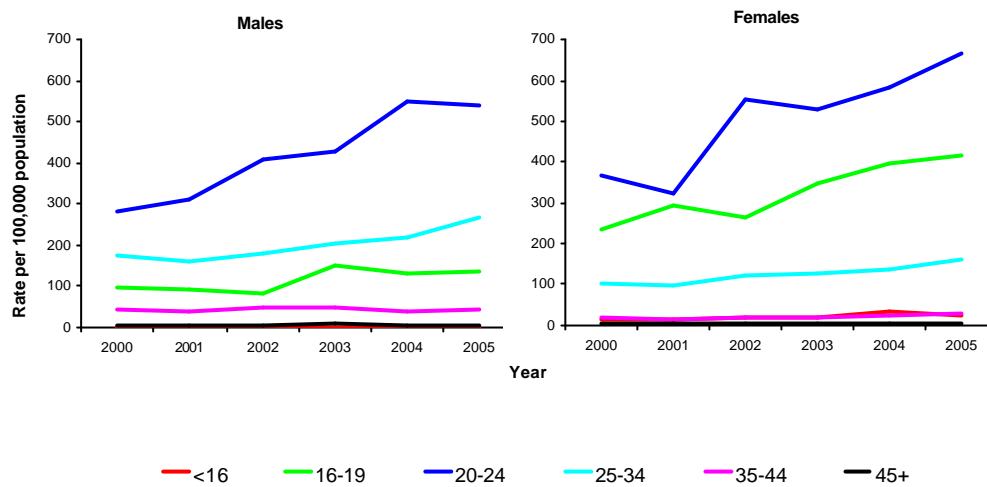


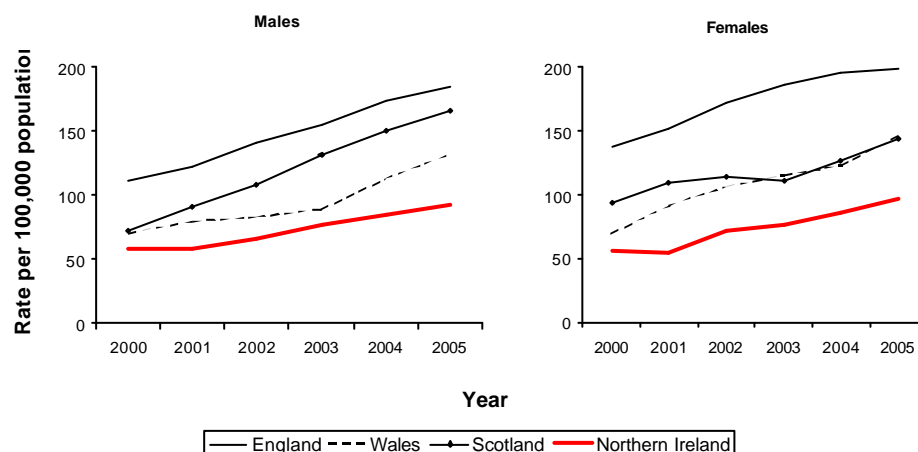
Figure 3.2: Diagnoses of uncomplicated chlamydial infection, by age and gender, Northern Ireland, 2000-2005



Diagnostic rates in women have been highest in the 16-24 years age groups peaking between 20 and 24 years. In men, the highest rates are in the 20-34 years age groups, peaking between 20 and 24 years. Infection rates under 25 years have been consistently higher in females whereas infection rates from 25 years have been consistently higher in males (Figure 3.2). Between 2000 and 2005 no diagnoses of uncomplicated chlamydial infection were made in males under 16 years, compared to 48 in females. Diagnostic rates among women fall after 24 years of age due to changes in sexual behaviour as well as decreased susceptibility.

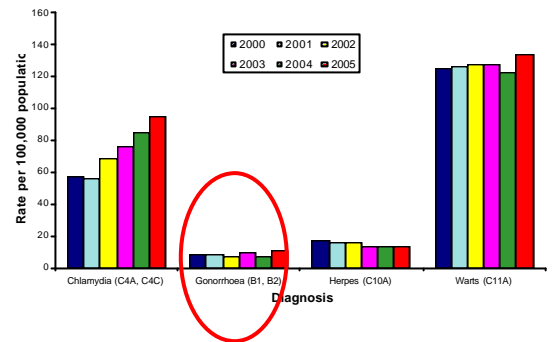
The proportion of total male diagnoses attributed to MSM has increased from 2% in 2000 to 7% in 2005.

Figure 3.3: Rates of uncomplicated chlamydial infection by gender and country, 2000-2005



Rates of uncomplicated chlamydial infection are increasing throughout the United Kingdom and are highest in England and lowest in Northern Ireland (Figure 3.3).

Rates of selected diagnoses, Northern Ireland, 2000-05



4: Gonorrhoea

Gonorrhoea is a bacterial STI caused by *Neisseria gonorrhoeae*. Untreated, gonorrhoea can enter the blood stream or spread to the joints, and in women can cause PID, ectopic pregnancy and infertility. An infected pregnant woman may pass the infection to her baby during delivery.

While diagnostic rates in Northern Ireland remain the lowest in the UK, 2005 saw a large increase in diagnoses in males, compared with 2004.

During 2005:

Uncomplicated gonococcal infection:

- ❖ There were 182 new episodes of uncomplicated gonorrhoea diagnosed at GUM clinics in Northern Ireland (Table 4.1)
- ❖ 162 (89%) of these were diagnosed in men and 20 (11%) in women
- ❖ The highest rates of infection in both men and women were diagnosed in the 20-24 years age group
- ❖ However, the rate of infection in 20-24 year old males is 3.5 times higher than in 20-24 year old females
- ❖ 65% of female diagnoses were in the 20-24 years age group
- ❖ In males, the proportion of diagnoses was more evenly distributed throughout the age groups – 38% were 16-24 years, 35% were 25-34 years and 23% were 35-44 years
- ❖ 40% (64/162) of the total male diagnoses were attributed to MSM

Complicated gonococcal infection:

- ❖ There were 2 new episodes of complicated gonococcal infection diagnosed at GUM clinics in Northern Ireland – both of these were diagnosed in females

Two cases of gonococcal ophthalmia neonatorum were also diagnosed.

Table 4.1: Diagnoses and age specific rates of uncomplicated gonorrhoea, 2004-2005, Northern Ireland

		2004			2005			% increase/decrease		
		M	F	Total	M	F	Total	M	F	Total
Number of diagnoses	<16	0	1	1	0	0	0	-	-100	-100
	16-19	17	8	25	14	3	17	-18	-63	-32
	20-24	32	5	37	47	13	60	47	160	62
	25-34	46	3	49	56	2	58	22	-33	18
	35-44	9	1	10	37	1	38	311	0	280
	45+	1	1	2	8	1	9	700	0	350
	Total	105	19	124	162	20	182	54	5	47
Age-specific rate per 100,000 population	<16	0	3	1	0	0	0	-	-100	-100
	16-19	31	16	24	26	6	16	-16	-63	-33
	20-24	54	9	32	76	22	50	41	144	56
	25-34	41	3	21	50	2	25	22	-33	19
	35-44	7	1	4	29	1	15	314	-	275
	45+	0	0	0	3	0	1	-	-	-
	Total	13	2	7	19	2	11	46	0	57

Trends: 2000-2005

Between 2000 and 2005, diagnoses of uncomplicated gonorrhoea have varied between 117 in 2002 and 182 in 2005 (Figure 4.1). Diagnoses increased by 47% from 124 to 182 between 2004 and 2005, largely accounted for by the increase seen in MSM. There has been less variation in diagnoses in females, with an average of 20 per year. Diagnoses of complicated gonorrhoea are low with approximately three diagnosed annually.

Figure 4.1: Diagnoses of gonorrhoea, Northern Ireland, 2000-2005

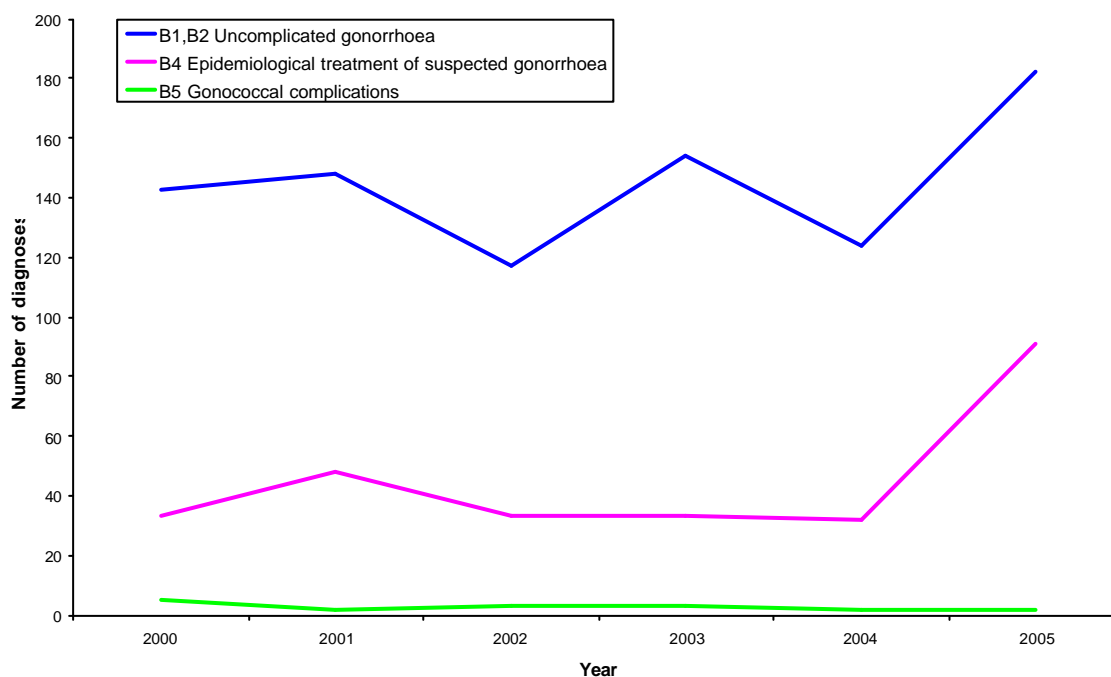
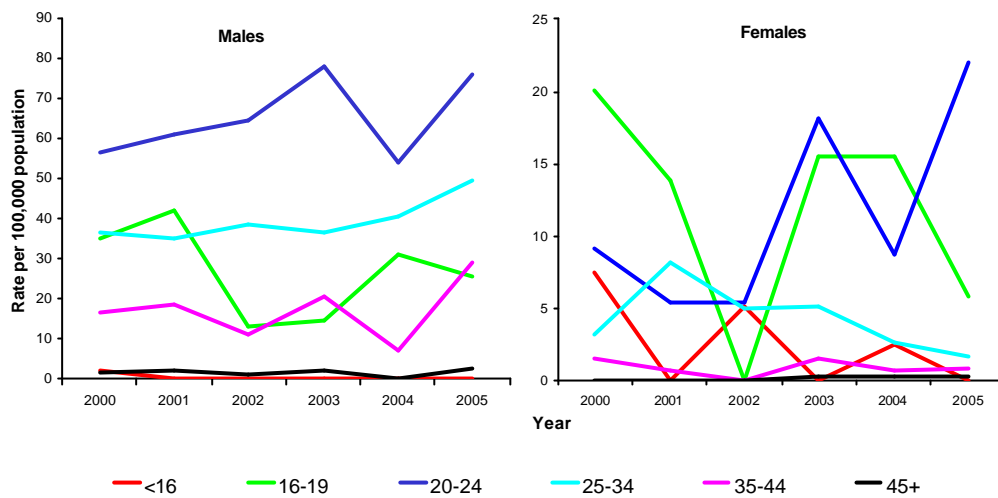


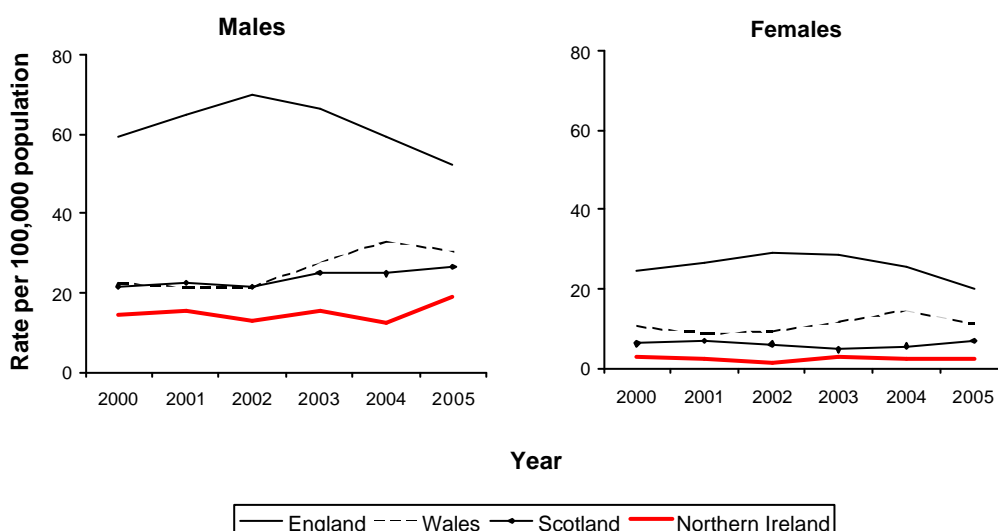
Figure 4.2: Diagnoses of uncomplicated gonorrhoea infection, by age and gender, Northern Ireland, 2000-2005



Although there is no clear trend due to the small numbers involved, diagnostic rates in females are generally highest in the 16-24 years age groups. In men, the highest infection rates are in the 20-34 years age groups, peaking between 20 and 24 years. Between 2000 and 2005 six diagnoses were made in females under 16 years compared to one in a male (Figure 4.2).

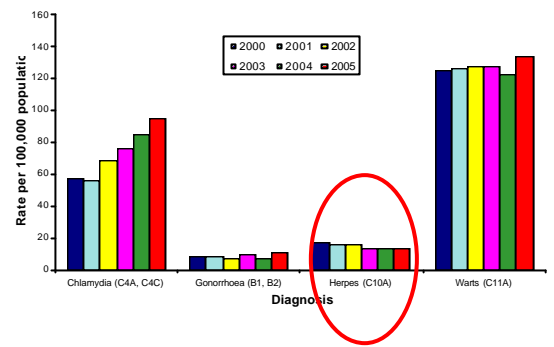
The proportion of the total male diagnoses attributed to MSM has increased from 9% in 2000 to 40% in 2005.

Figure 4.3: Rates of uncomplicated gonococcal infection by gender and country, 2000-2005



Between 2000 and 2005 diagnostic rates of gonorrhoea in Northern Ireland have consistently been the lowest of all UK countries for both males and females (Figure 4.3).

Rates of selected diagnoses, Northern Ireland, 2000-05



5: Genital Herpes

Genital herpes is caused by the herpes simplex virus (HSV) of which there are two distinct subtypes. Type 2 is almost exclusively associated with genital infection. While historically, HSV1 was mainly associated with oral infection the proportion of genital HSV attributed to HSV1 in the UK is increasing. Genital HSV infection may facilitate HIV transmission, can cause severe systemic disease in those with impaired immunity, and can be potentially fatal to neonates.

Diagnostic rates of genital herpes in Northern Ireland are the lowest of all the UK countries.

During 2005:

- ❖ There were 366 new episodes of genital herpes diagnosed at GUM clinics in Northern Ireland in 2005
- ❖ 251 (69%) of these were diagnosed in women and 115 (31%) in men
- ❖ 238 (65%) of the total attendances for herpes in 2005 were for treatment of first infections and 128 (35%) were for treatment of recurrent infection
- ❖ 43% of the male diagnoses (49/115) were recurrent infections compared with 31% (79/251) of the female diagnoses
- ❖ The highest rates of first infections in both men and women were diagnosed in the 20-24 years age group (Table 5.1)
- ❖ Rates of infection in all age groups under 45 years were higher in females, and in particular the rate of infection in 16-19 year old women was almost seven times higher in than men in the same age group, and more than three times higher in females in the 20-24 years age group than males
- ❖ 8% (9/115) of the total male diagnoses were attributed to MSM

Table 5.1: Diagnoses and age specific rates of genital herpes (1st attack), 2004-2005, Northern Ireland

		2004			2005			% increase/decrease		
		M	F	Total	M	F	Total	M	F	Total
Number of diagnoses	<16	0	1	1	0	1	1	-	-	-
	16-19	2	32	34	6	39	45	200	22	32
	20-24	28	56	84	20	64	84	-29	14	0
	25-34	25	39	64	28	46	74	12	18	16
	35-44	11	22	33	8	19	27	-27	-14	-18
	45+	3	3	6	4	3	7	33	-	17
	Total	69	153	222	66	172	238	-4	12	7
Age-specific rate per 100,000 population	<16	0	3	1	0	3	1	-	-	-
	16-19	4	62	32	11	76	42	175	23	31
	20-24	47	98	72	32	108	70	-32	10	-3
	25-34	22	34	28	25	40	32	14	18	14
	35-44	9	17	13	6	15	11	-33	-12	-15
	45+	1	1	1	1	1	1	0	0	0
	Total	8	18	13	8	20	14	-	11	8

Trends: 2000-2005

First diagnoses of genital herpes have decreased by 15% between 2000 and 2005 due to a decrease in male diagnoses of almost 40% (Figure 5.1). Diagnoses in females have remained stable with an average of 168 diagnoses per year accounting for more than 60% of the total each year. However, there was 12% increase in female diagnoses between 2004 and 2005 (Table 5.1).

Figure 4.1: Diagnoses of genital herpes, Northern Ireland, 2000-2005

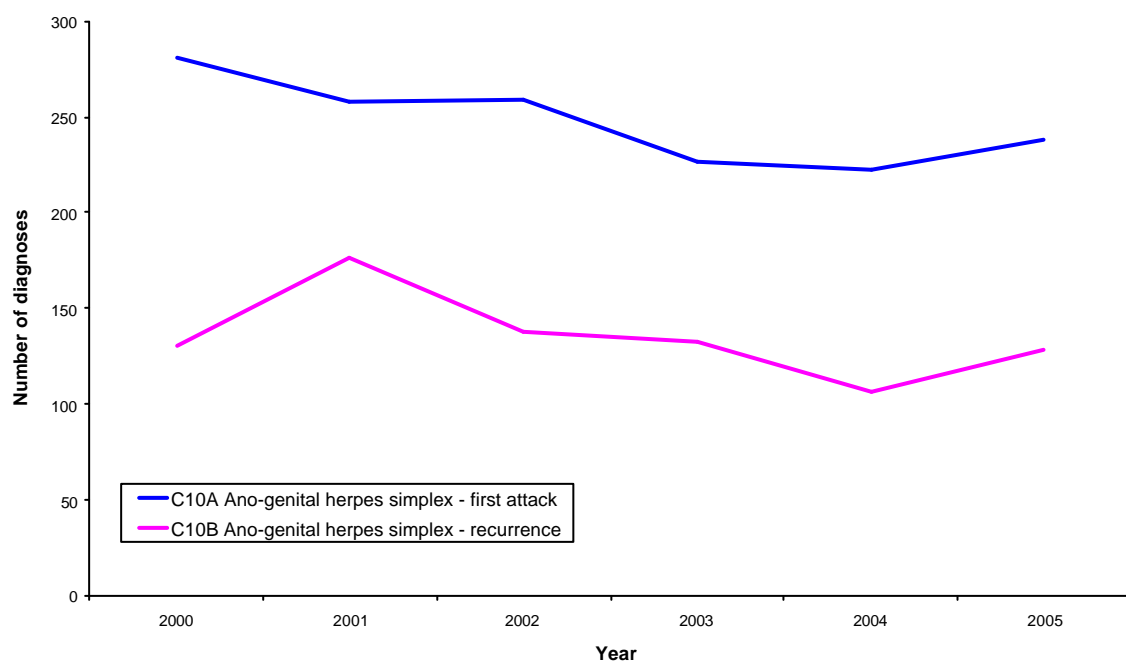
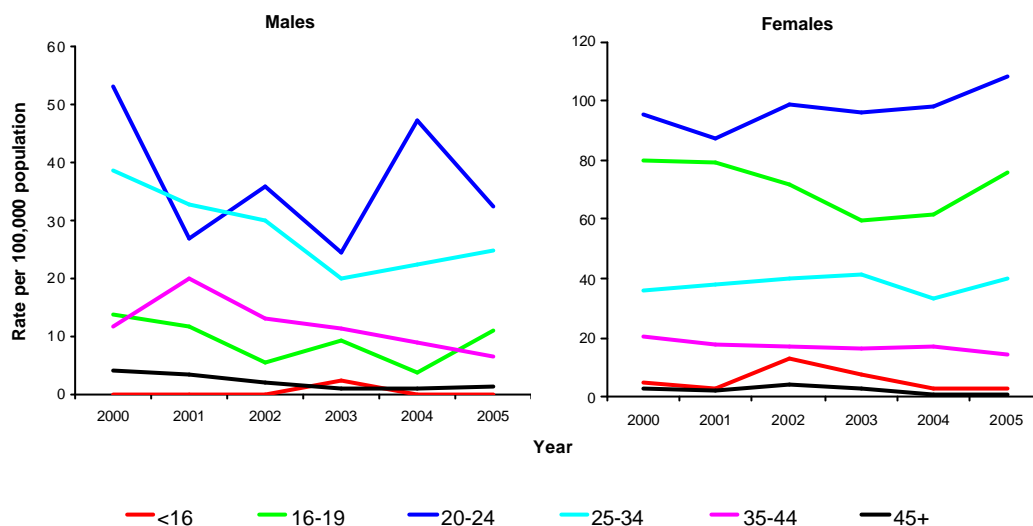


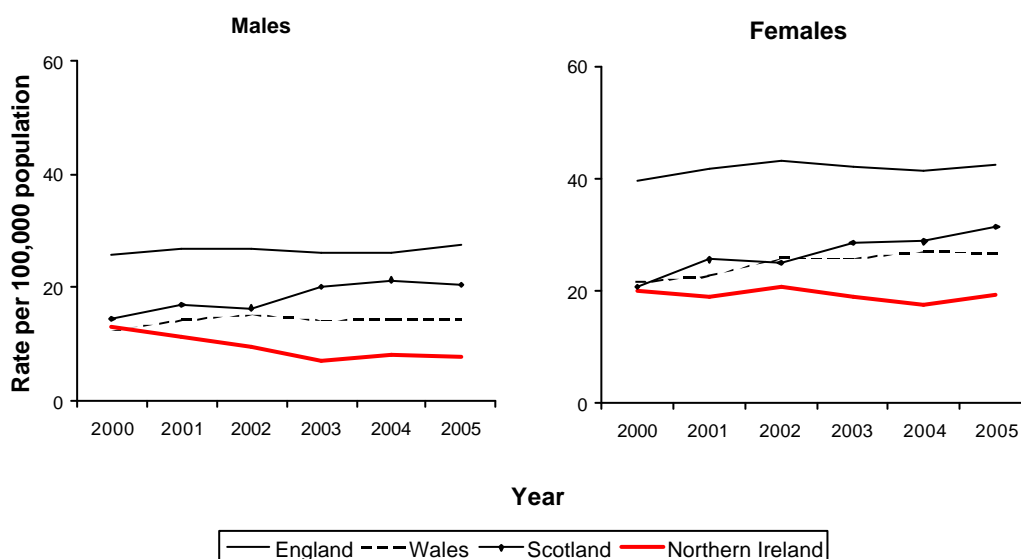
Figure 4.2: Diagnoses of genital herpes (1st attack), by age and gender, Northern Ireland, 2000-2005



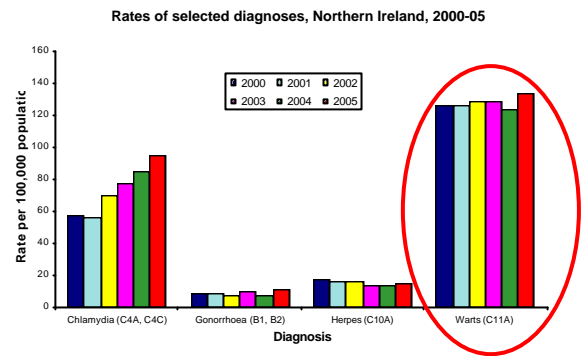
Diagnostic rates in women have been highest in the 16-24 years age groups, peaking between 20 and 24 years. In men, the highest rates are in the 20-34 years age groups, peaking between 20 and 24 years. Rates of infection in all age groups under 45 years have been higher in females than in males of the same age. Between 2000 and 2005 there has been one diagnosis of first infection of genital herpes in males under 16 years, compared to 13 diagnoses in females under 16 years (Figure 5.2).

The proportion of total male diagnoses attributed to MSM has increased from 3% in 2000 to 8% in 2005.

Figure 5.3: Rates of genital herpes (1st attack) by gender and country, 2000-2005



Diagnostic rates of infection are lower for both males and females in Northern Ireland compared with those of the other UK countries (Figure 5.3).



6: Genital warts

Genital warts are caused by human papillomavirus (HPV). More than 90 HPV types have been identified of which approximately one third are sexually acquired. Although more than 20 different types of HPV have been linked to cervical cancer, these particular types are less frequently associated with genital warts.

Diagnostic rates in males in Northern Ireland are similar to those in the rest of the UK, while rates in females in Northern Ireland are higher than in Scotland or Wales.

During 2005:

- ❖ There were 3,131 new episodes of genital warts diagnosed at GUM clinics in Northern Ireland in 2005
- ❖ 1,673 (53%) of these were diagnosed in men and 1,458 (47%) in women
- ❖ 2,306 (74%) of the total attendances for genital warts in 2005 were for treatment of first infections and 825 (26%) were for treatment of recurrent infection
- ❖ 28% of the male diagnoses (465/1,673) were recurrent infections compared with 25% (360/1,458) of the female diagnoses
- ❖ The highest rates of first infections in both men and women were diagnosed in the 20-24 years age group (Table 6.1)
- ❖ 38% of male diagnoses and 37% of female diagnoses were in the 20-24 years age group
- ❖ The rate of infection in women aged 16-19 years was 2.7 times higher than in men of the same age, but rates of infection in those aged over 24 years were higher in men (particularly in the 35-44 years age group)
- ❖ 3% (53/1,673) of the total male diagnoses were attributable to MSM

Table 6.1: Diagnoses and age specific rates of genital warts (1st attack), 2004-2005, Northern Ireland

		2004			2005			% increase/decrease		
		M	F	Total	M	F	Total	M	F	Total
Number of diagnoses	<16	0	9	9	0	6	6	-	-33	-33
	16-19	86	259	345	103	267	370	20	3	7
	20-24	397	358	755	460	403	863	16	13	14
	25-34	387	278	665	443	296	739	14	6	11
	35-44	133	110	243	150	89	239	13	-19	-2
	45+	56	28	84	52	37	89	-7	32	6
Total		1059	1042	2101	1208	1098	2306	14	5	10
Age-specific rate per 100,000 population	<16	0	23	11	0	16	8	-	-30	-27
	16-19	157	501	324	189	518	349	20	3	8
	20-24	668	626	648	745	681	714	12	9	10
	25-34	343	239	291	393	257	324	15	8	11
	35-44	106	84	95	119	68	93	12	-19	-2
	45+	19	8	14	18	11	14	-5	38	0
Total		127	119	123	143	125	134	13	5	9

Trends: 2000-2005

Diagnoses of initial infections of genital warts have increased by just 9% since 2,117 episodes were recorded in 2000. Diagnoses remained steady and actually decreased in 2004 before increasing in 2005 (Figure 6.1). Males and females have been affected equally although age distribution differs between the sexes.

Figure 6.1: Diagnoses of genital warts, Northern Ireland, 2000-2005

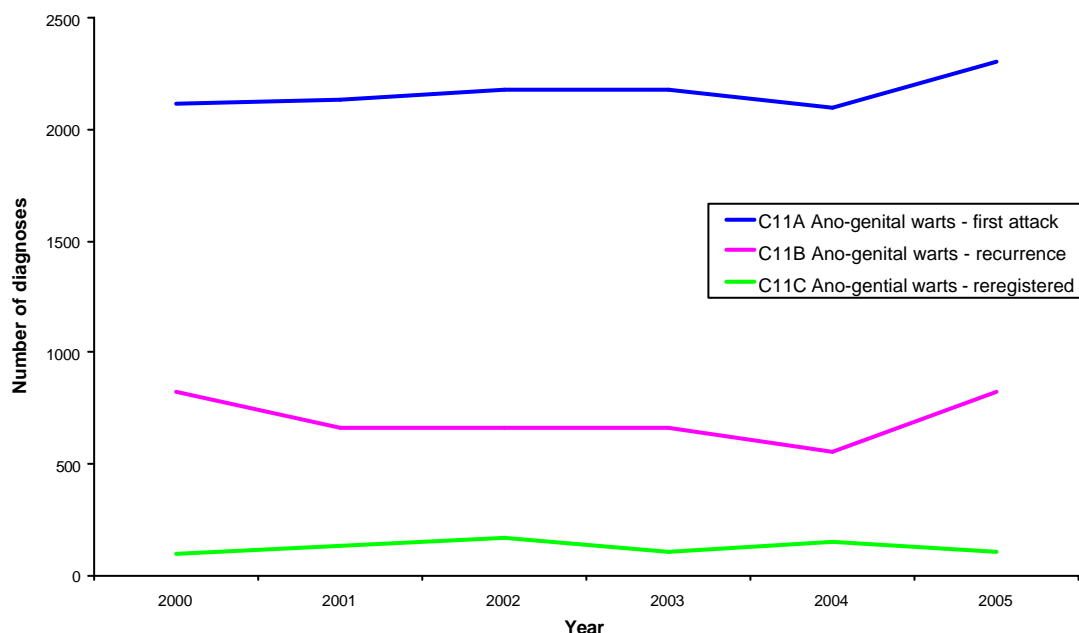
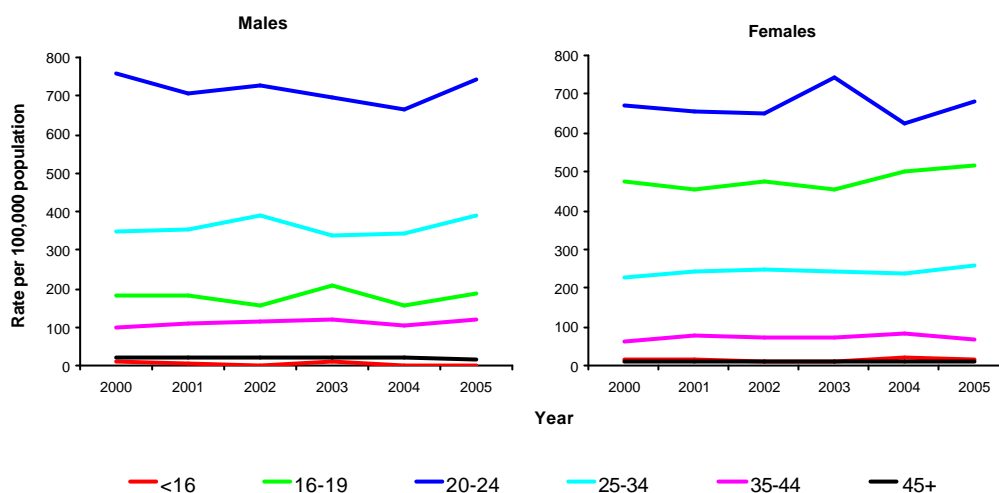


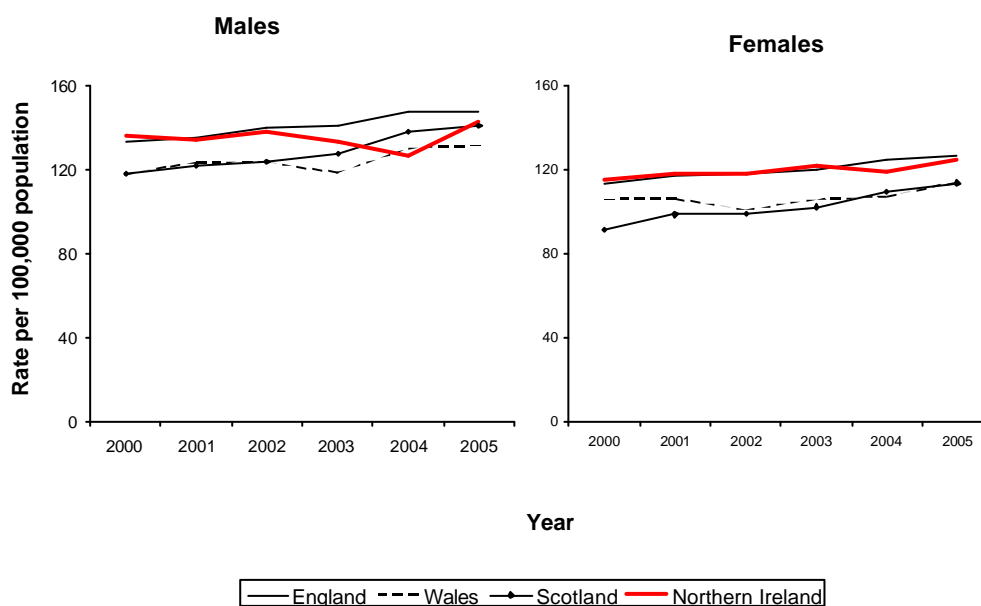
Figure 6.2: Diagnoses of genital warts (1st attack), by age and gender, Northern Ireland, 2000-2005



Diagnostic rates in women have been highest in the 16-24 years age groups, peaking between 20 and 24 years. In men, the highest rates are in the 20-34 years age groups, peaking between 20 and 24 years. Infection rates under 20 years have been consistently higher in females than males whereas infection rates from 20 years have been higher in males. Between 2000 and 2005 12 diagnoses of first infection of genital warts were made in males under 16 years, compared to 39 in females (Figure 6.2).

The proportion of total male diagnoses attributed to MSM has remained stable at 2-3% since 2000.

Figure 6.3: Rates of genital warts (1st attack) by gender and country, 2000-2005



Diagnostic rates in males in Northern Ireland are similar to those in the rest of the UK. Diagnostic rates in females in Northern Ireland are higher than in Scotland or Wales (Figure 6.3).