2024 NFPRHA NATIONAL CONFERENCE

WASHINGTON, DC
MAY 19-22

PEER-TO-PEER: PROMISING APPROACHES FOR ADDRESSING CONGENITAL SYPHILIS EPIDEMIC

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CONTRIBUTORS

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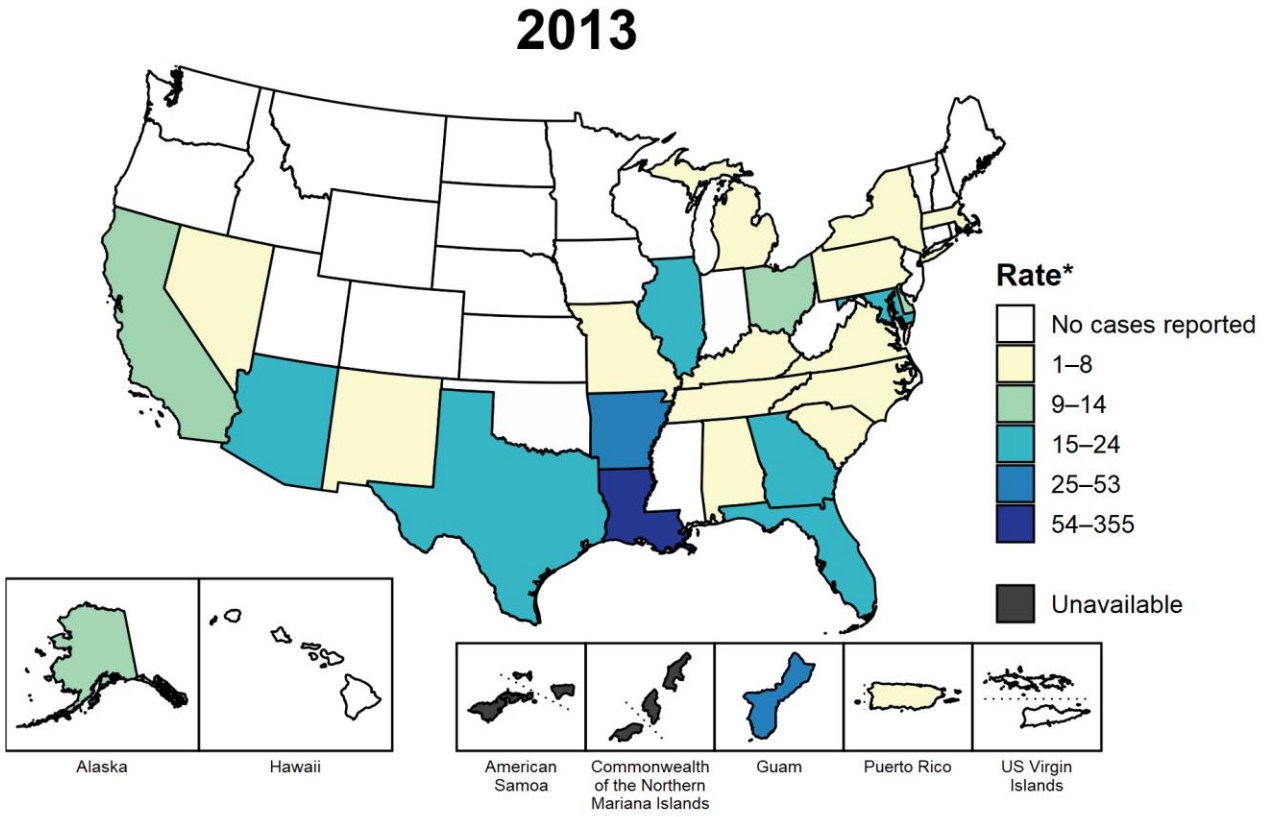
Objectives

As a result of this peer-to-peer session, attendees will be able to:

- Summarize the epidemiology of syphilis and congenital syphilis in the US
- Examine why syphilis during pregnancy goes undetected or untreated – or is treated but reinfection occurs
- Explore how family planning provides can play a role in the response to the syphilis and congenital syphilis epidemics
- Identify opportunities to contribute to their states' policy-level response to the syphilis and congenital syphilis epidemics

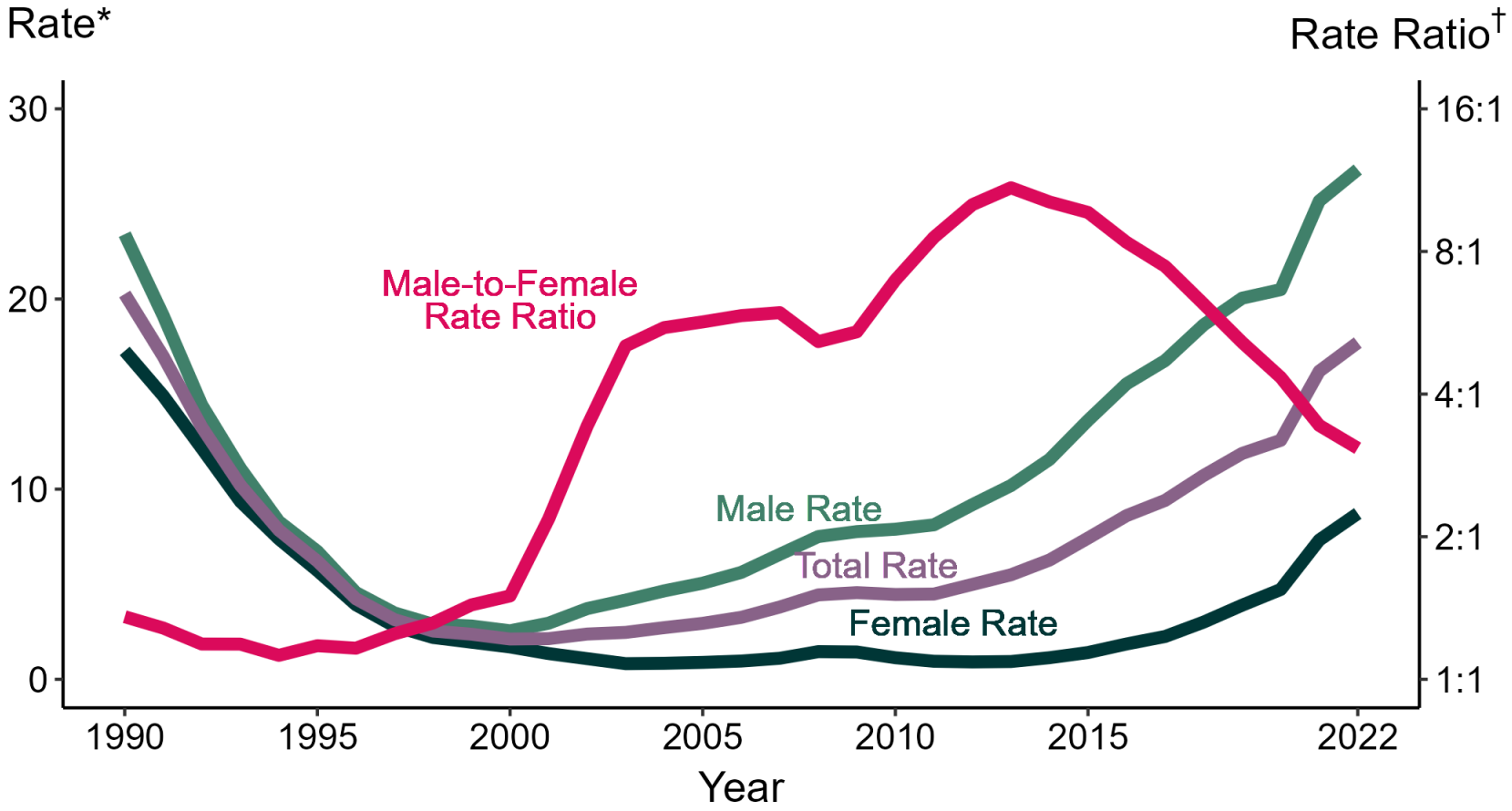
National Family Planning & Reproductive Health Association

Congenital Syphilis — Rates of Reported Cases by Year of Birth and Jurisdiction, United States and Territories, 2013–2022



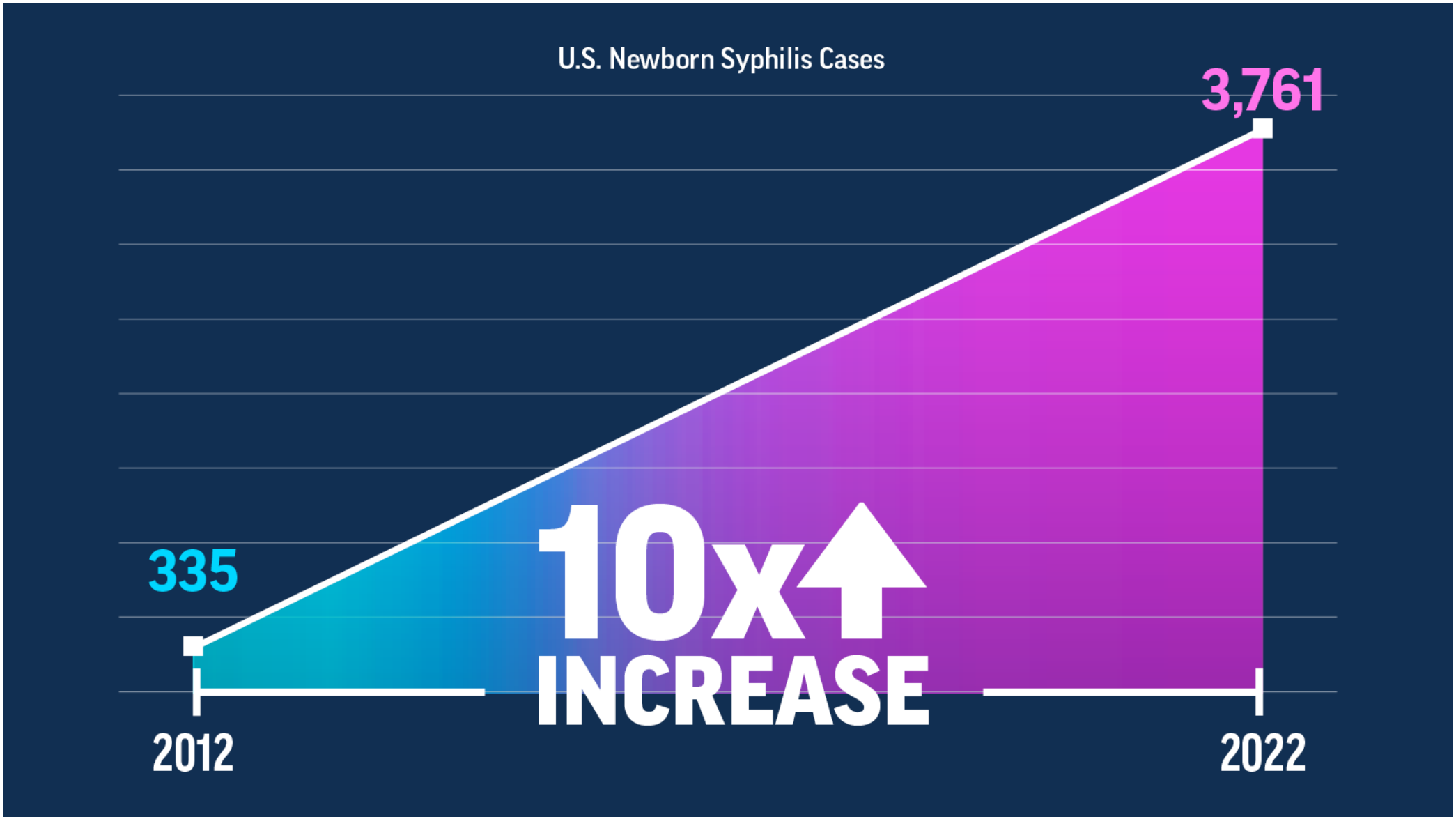
* Per 100,000 live births

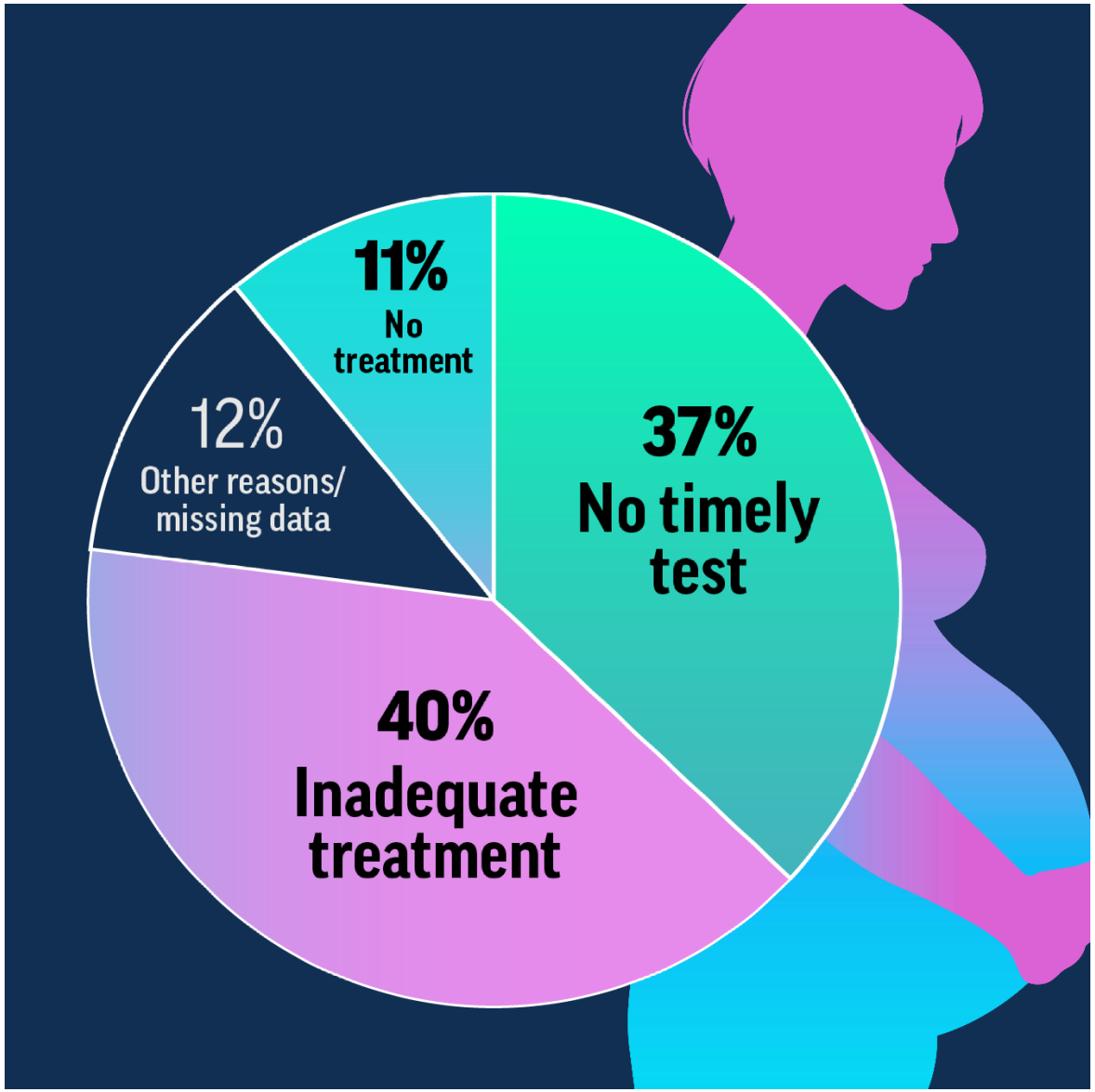
Primary and Secondary Syphilis — Rates of Reported Cases by Sex and Male-to-Female Rate Ratios, United States, 1990–2022



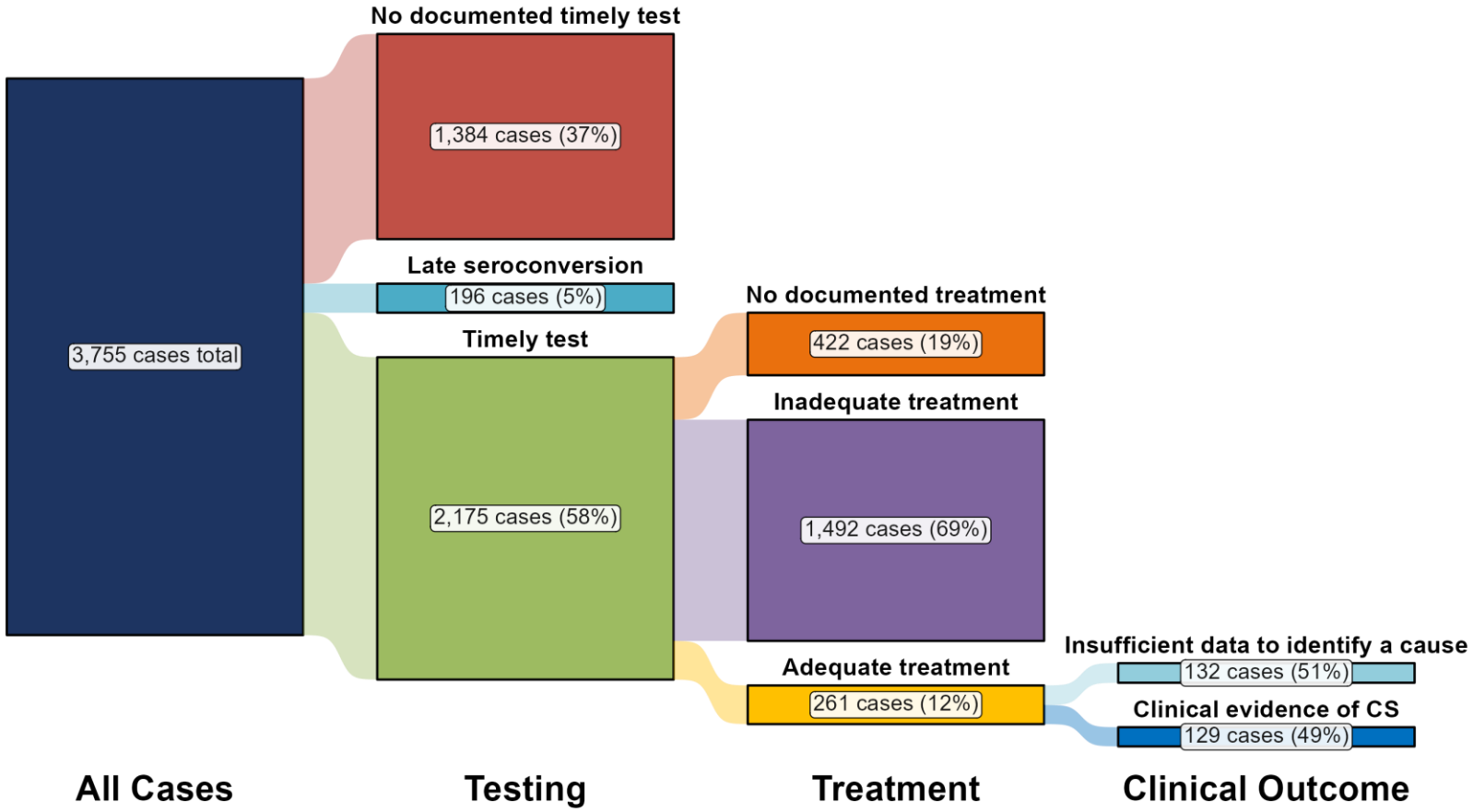
* Per 100,000

† Log scale

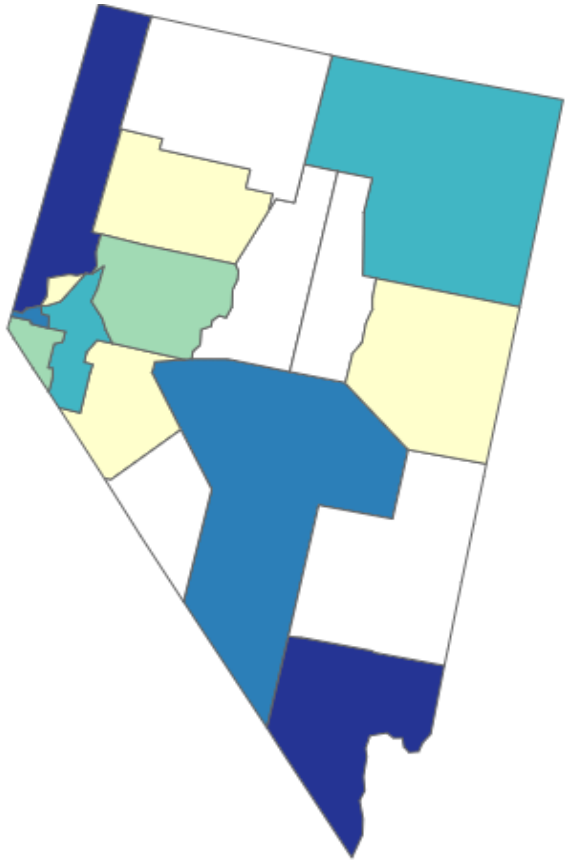

U.S. Newborn Syphilis Cases
3,761
335
10x
INCREASE
2012
2022


11%
No treatment
12%
Other reasons/ missing data
37%
No timely test
40%
Inadequate treatment

Congenital Syphilis — Distribution of Receipt of Testing and Treatment by Pregnant Persons with a Congenital Syphilis Outcome, United States, 2022



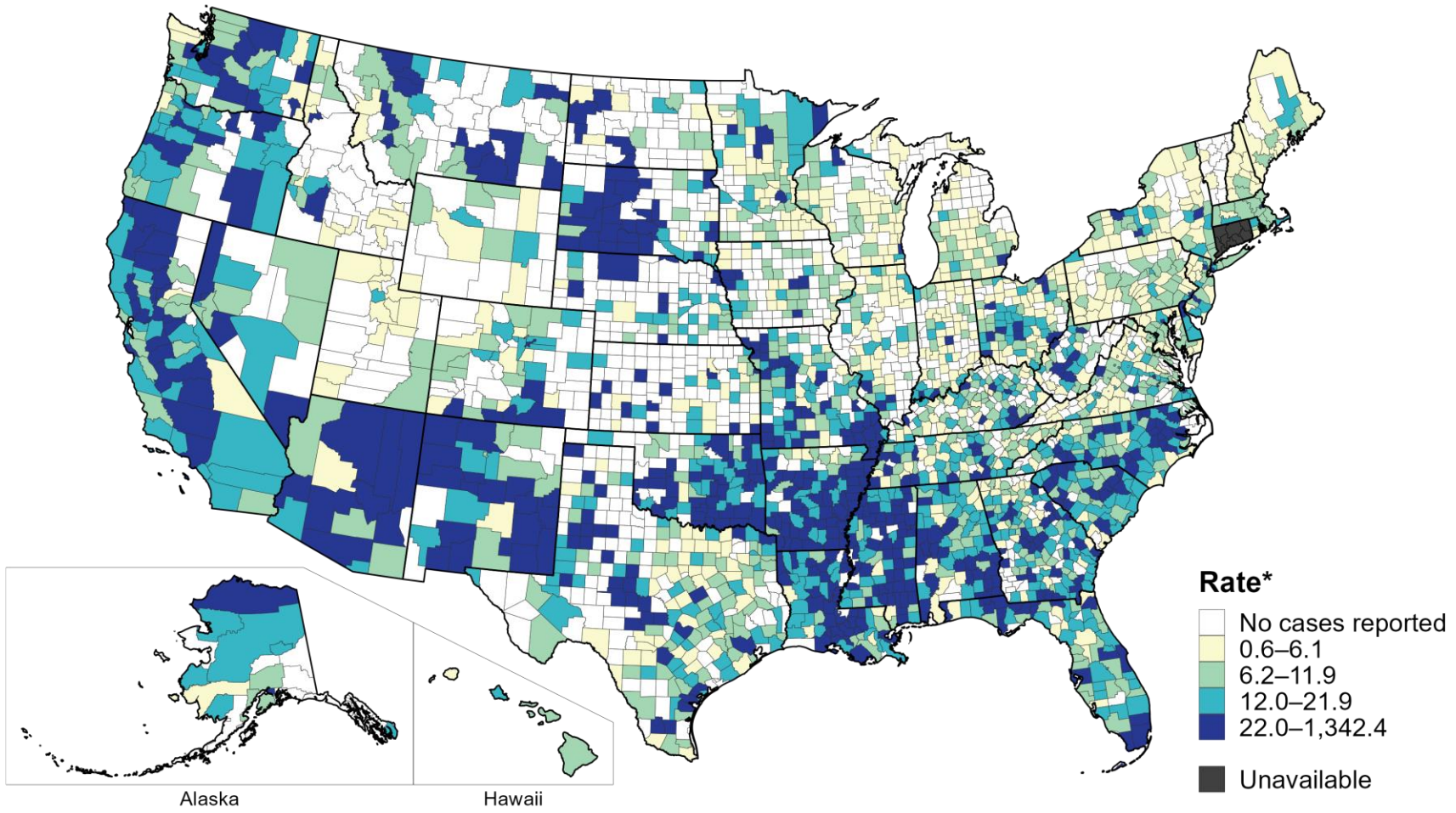
Primary and Secondary Syphilis — Rates of Reported Cases by County, Nevada, 2022



Cases

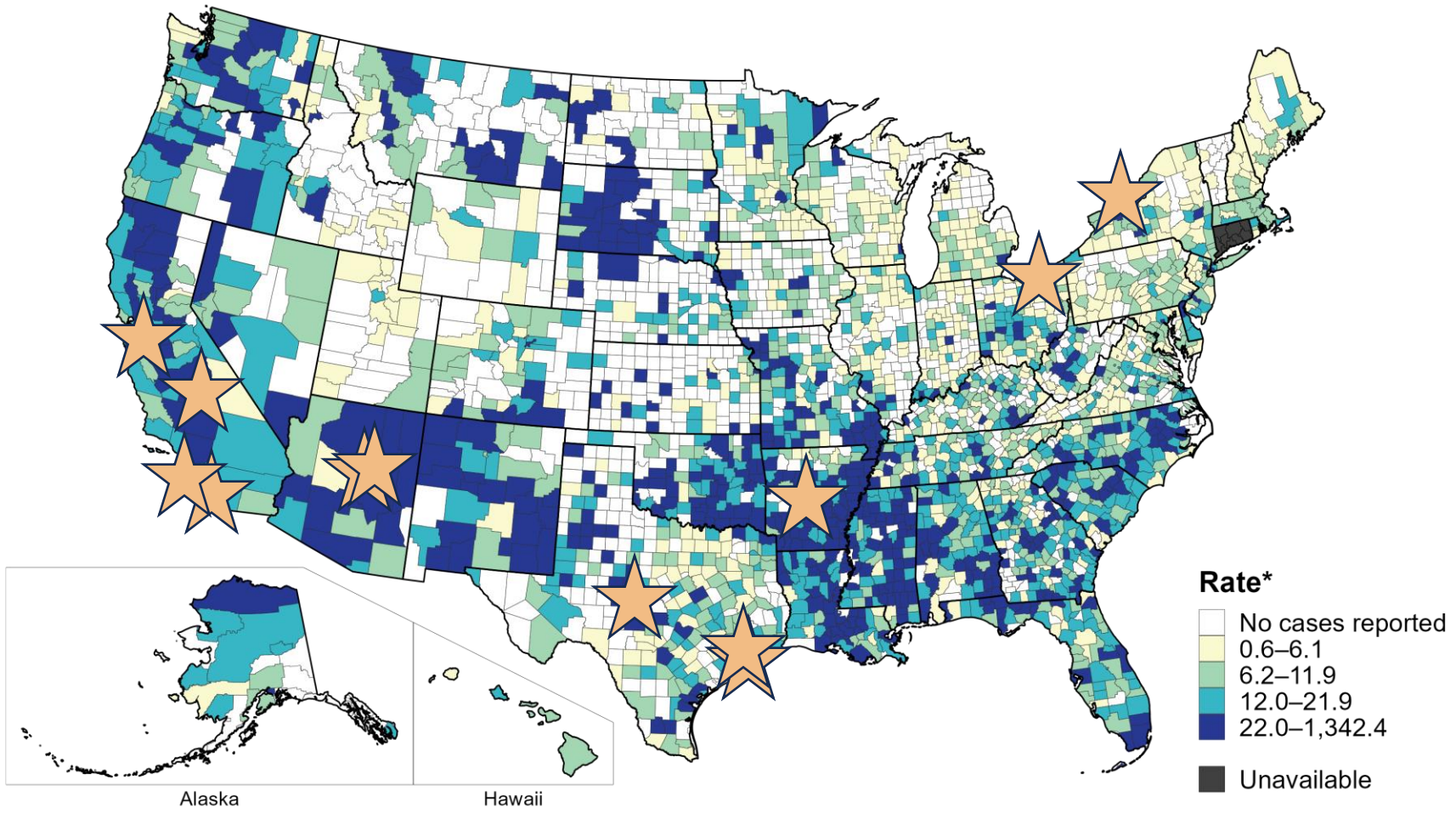
0	1 - 1	2 - 4	5 - 6	9 - 11	153 - 708

Primary and Secondary Syphilis — Rates of Reported Cases by County, United States, 2022



* Per 100,000

CTC-SRH Primary Syphilis Point of Care Testing Implementation Project Pilot Sites



* Per 100,000

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PEER-TO-PEER DISCUSSION

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CLINICAL PROTOCOL TEMPLATE

SYPHILIS SCREENING, DIAGNOSIS & TREATMENT

This template pr
protocols for sc

A clinical pro
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Refer to the N
(NFPRHA's) r
for more info

TREATMENT OF SYPHILIS

	Primary and Secondary Syphilis (including persons with HIV Infection)	Early Latent Syphilis	Late Latent Syphilis or Latent Syphilis of Unknown Duration	Persons with p allergy or benz penicillin not a
Plan (Pharmacologic Treatment) **NOTE:** Parenteral penicillin G is the *only therapy* with documented efficacy during pregnancy. Pregnant patients should be referred or treated on-site (see **Appendix**)	• Benzathine penicillin G 2.4 million units IM in a single dose. **NOTE:** Bicillin LA comes in 2 mL (1.2 mU) and 4 mL (2.4 mU) syringes. The 2 mL dose requires *two* syringes per treatment. • **Alternatives** - Doxycycline 100 mg orally twice a day for 14 days - Tetracycline 500 mg orally 4 times a day for 14 days - Ceftriaxone 1 gm IV or IM daily for 10 days **NOTE:** Persons with a typical ulcer, newly reactive serology (i.e., VDRL or RPR, EIA/CIA, or rapid treponemal test), a newly reactive VDRL or RPR, and no history of previous syphilis may be treated for primary syphilis prior to receiving results of confirmatory testing.	• Benzathine penicillin G 2.4 million units IM in a single dose. • **Alternatives** - Doxycycline 100 orally twice a day for 14 days - Tetracycline 500 orally 4 times a day for 14 days - Ceftriaxone 1 gm IV or IM daily for 10 days	• Benzathine penicillin G 7.2 million units total administered as 3 doses of 2.4 million units IM each at 1-week intervals. • **Alternatives** - Doxycycline 100 mg orally twice a day for 28 days - Tetracycline 500 orally 4 times a day for 28 days	**Primary and Sec Syphilis**: • Doxycycline twice daily fo **Latent Syphilis:** • Doxycycline twice daily fo **NOTE:** If complia therapy or follow ensured, desensi treatment with b penicillin is recor CDC. Treatment performed in cor an infectious dis specialist. Careful clinical a follow-up of pers any alternative th essential.

NOTE: There have been shortages of Benzathine penicillin G (Bicillin® L-A) in the US. Several organizations have published guidelin responding to limited supplies by prioritizing who must receive Bicillin and advising that all others receive alternative regimens. Plea with your state health department's guidance on prioritization. If none, the California Department of Public Health (CDPH) STD Cont recommends the following prioritization categories:

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APPENDIX: TREATMENT OF SYPHILIS IN PREGNANCY

In 2021, 17% of women of childbearing age diagnosed with syphilis were pregnant. Congenital syphilis cases increased 1,500% between 2012 and 2021. These trends mirror a sharp increase in early syphilis among females, which increased more than 1,113% during the same period.

Under ideal circumstances, a pregnant person who is diagnosed with syphilis and planning to continue the pregnancy should be managed by their prenatal care provider. This allows the clinician to both treat the patient and perform the necessary follow-up titers to ensure that syphilis is cured. Continuity of care is fractured if a family planning provider begins treatment, and the prenatal care provider must do the follow-up care.

However, studies have shown that 40% of pregnant people with syphilis receive no prenatal care[9,10], and for that reason, if transfer for prenatal care is delayed or unavailable, family planning providers should treat pregnant people found to have syphilis to avoid loss to follow-up.

Given that the only treatment for syphilis in pregnancy is benzathine penicillin, if a pregnant person is penicillin-allergic, they must go through the penicillin desensitization process. This often is done by a perinatologist, sometimes with the consultation of an infectious disease physician or allergist.

If a pregnant person is committed to having an abortion, there is no longer a concern about vertical transmission to a fetus resulting in congenital syphilis. In this case, treatment can be provided using the same regimens as in non-pregnant people.

The 2021 CDC STI Treatment Guidelines section on treatment of syphilis in pregnancy includes the following points:

- All patients who have syphilis should be offered testing for HIV at the time of diagnosis.
- Risk factors for syphilis during pregnancy include sex with multiple partners; sex in conjunction with drug use or transactional sex, late entry to prenatal care (i.e., first visit during the second trimester or later) or no prenatal care; methamphetamine or heroin use; incarceration of the pregnant person or their partner; and being unhoused or experiencing housing instability.
- Antepartum screening can be performed by using the traditional syphilis screening algorithm or by the reverse sequence algorithm.
- Pregnant people with positive treponemal screening tests (e.g., EIA, CIA, or immunoblot) should have additional quantitative nontreponemal testing because titers are essential for monitoring treatment response.
- Any person who has a fetal death after 20 weeks' gestation should be tested for syphilis.

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THANK YOU

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