2024 Syphilis Screening Guidelines[+]

Cisgender women (including pregnant persons) and cisgender men who have sex with women**
Universal screening at least once
All sexually active* persons aged 45 years and under if they have not tested since January 2021
Annual or more frequent testing
Test sexually active* patients with any of the following indications at least annually and whenever they present for care up to every 3 months: Persons who inject drugs Persons who use methamphetamine or nonprescription opioids Persons who are houseless or unstably housed Person engaged in transactional sex Persons entering correctional facilities or with a history of incarceration in the prior 2 years Persons with a history of syphilis or gonorrhea in the prior 2 years Persons living with HIV who are sexually active outside of a mutually monogamous relationship Women whose male partners have sex with both men and women Persons with a sex partner with any of the above indications for syphilis testing
Screening in pregnancy
Pregnant persons should be tested at the following times: First prenatal care visit Time of 3rd trimester laboratory testing - typically done at 24-28 weeks gestation Time of delivery Test pregnant persons with no or unknown prenatal care any time they present to a clinical setting (i.e., emergency department, jail, substance use treatment facilities, OB triage, labor and delivery, etc.) Pregnant persons with fetal demise at $\geq$20 weeks gestation
Cisgender men who have sex with men (MSM) and transgender persons who have sex with men**
Test sexually active* MSM and transgender patients who have sex with men with any of the following indications every 3-4 months: History of syphilis, gonorrhea, or chlamydial infection in the prior 2 years Use methamphetamine and/or opioids and/or injection drug use $\geq$10 sex partners in the prior year Taking HIV pre-exposure prophylaxis (PrEP) HIV-negative persons who have had condomless anal sex with a man who is living with HIV or of unknown HIV status
Sexually active* MSM and transgender persons outside of mutually monogamous, seroconcordant partnerships should be tested for HIV/STI (including syphilis) annually.

[+]Medical providers should be especially vigilant in following these guidelines when caring for Black, Latinx, Indigenous, Native Hawaiian and Pacific Islander patients; patients from these communities are disproportionately affected by syphilis in WA State.

*Sexually active= any oral, anal, or front/vaginal sex in the last year or since last syphilis test

**Syphilis should be done as part of comprehensive HIV/STI testing that includes testing for HIV (if not living with HIV) and for gonorrhea and chlamydial infection at all exposed anatomical sites (urethra/vagina/cervix, rectum, pharynx).

Additional Syphilis Management Reminders:

• Understand the syphilis testing algorithm (traditional vs reverse sequence) that is available and used by your organization to guide which test(s) to order. Interpretation of results and diagnosis depend on current and prior clinical history. See Resources section and pages 3-4 below for additional information.

• Treat any person who reports sexual exposure to someone with syphilis, even in the absence of signs or symptoms of infection or a positive test result. Serological testing can be falsely negative early in infection (i.e., "incubating syphilis"). Test these individuals for syphilis but treatment should not be withheld awaiting test results.

• Treat all patients with signs or symptoms consistent with primary or secondary syphilis when they present for care. Clinicians should perform serological tests on patients with signs or symptoms of syphilis but should not wait for the results of such tests to provide treatment, particularly among pregnant women, persons who are houseless or unstably housed, and other persons for whom medical follow-up is difficult to ensure.

• Know the symptoms of primary syphilis: A syphilitic chancre is usually a firm ulcer at the site of inoculation; it is usually painless and may be associated with localized lymphadenopathy.

• Know the many symptoms of secondary syphilis: Rash is the most common symptom and may present as a generalized maculopapular rash on the torso with or without palmar and plantar lesions, though the rash may also be pustular; other presentations of rash include condylomata lata, mucous patches, and alopecia. Other symptoms include generalized malaise, lymphadenopathy, sore throat and arthralgias.

• Know the treatment of early syphilis (primary, secondary and early latent): long-acting benzathine penicillin (Bicillin LA) 2.4 million units intramuscularly once. Patients with late latent syphilis or syphilis of unknown duration require three injections spaced one week apart. If providers are uncertain that a patient will be able to return to for second and third doses of penicillin, they should provide a single dose of intramuscular penicillin AND prescribe doxycycline 100mg po bid for 28 days to complete a course of therapy for late and unknown duration syphilis.

• For clinical questions or technical assistance related to syphilis diagnosis, treatment, or management, free clinical consultations can be requested through the University of Washington's STD Prevention Training Center to be answered by email or phone within 1-5 business days: https://uwptc.squarespace.com/consults

• Report all cases of syphilis to your local health jurisdiction:

  o In King County, please Download the Sexually Transmitted Infection (STI) Case Reporting Form (PDF) Completed STI Case Reporting Forms can be faxed to 206-744-5622.

  o Report cases of syphilis outside of King County to your local public health jurisdiction using case report forms available on the Washington DOH website.

Resources

PHSKC HIV/STI/HCV Program: https://kingcounty.gov/en/legacy/depts/health/communicable-diseases/hiv-std.aspx

WA DOH STI Program: https://doh.wa.gov/you-and-your-family/illness-and-disease-z/sexually-transmitted-infections-sti

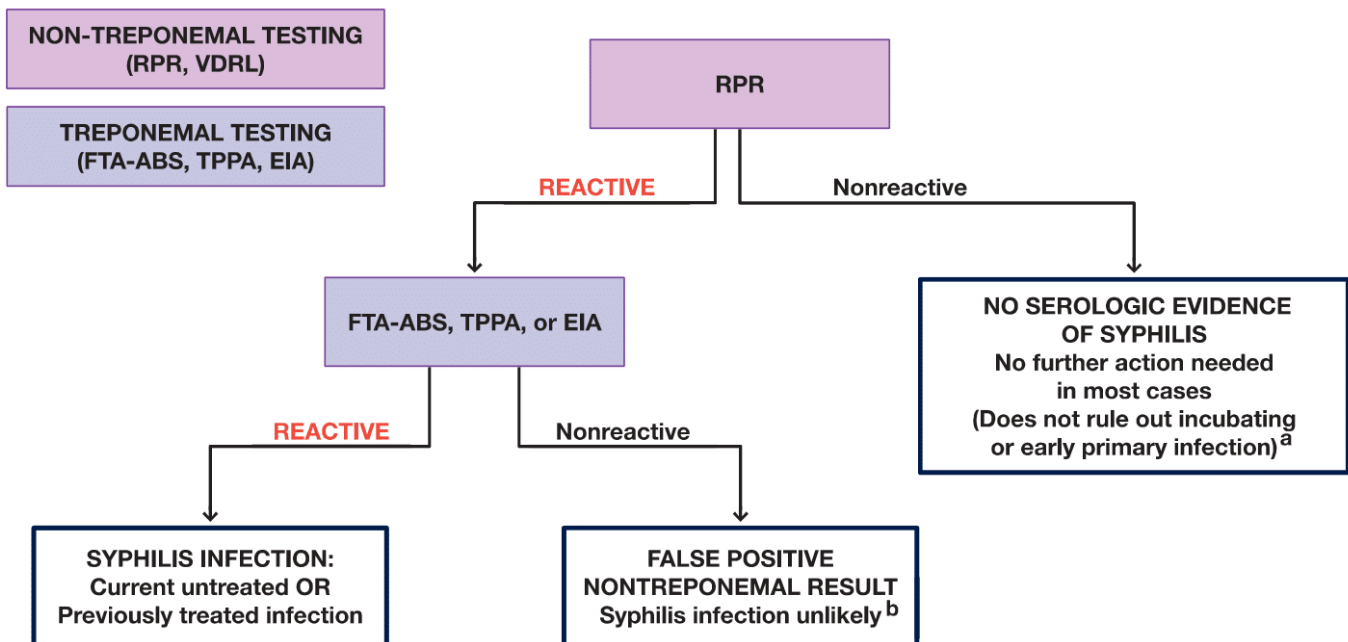
CDC STI Treatment Guidelines: https://www.cdc.gov/std/treatment-guidelines/default.htm

NYC Dept of Health Syphilis Management Review:
https://www.nycptc.org/x/Syphilis_Monograph_2019_NYC_PTC_NYC_DOHMH.pdf

National STD Curriculum (Syphilis): https://www.std.uw.edu/go/comprehensive-study/syphilis/core-concept/all

Oregon Health Authority: Syphilis Screening in Pregnancy Pocket Guide and Infant Syphilis Evaluation Pocket Guide

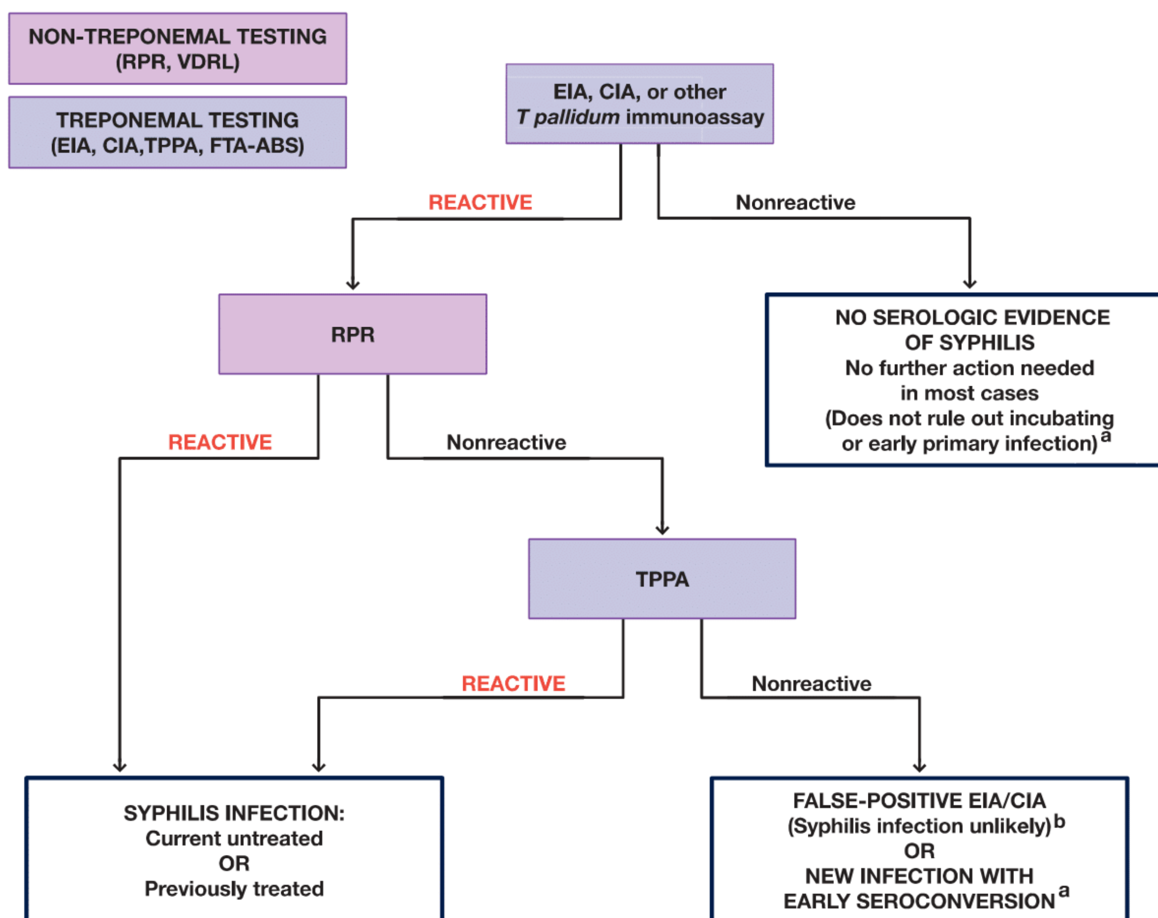
[SYPHILIS TESTING ALGORITHMS FROM THE NYC DEPARTMENT OF HEALTH AND MENTAL HYGIENE]



[a] Does not rule out incubating or early primary infection.

- **In a patient who reports an exposure,** in the past 90 days, to a sexual (or needle-sharing) partner newly diagnosed with syphilis, providers should offer presumptive treatment (See **Step 7**). If presumptive treatment is not administered, repeat serologic testing should be performed in 1 month and 3 months to rule out seroconversion following the recent exposure.
- **In a patient presenting with a skin lesion** on physical examination which is suspicious for primary syphilis, providers should consider presumptive treatment even in the face of nonreactive serologic results; lesion-based testing could also be performed if available. If presumptive treatment is not administered, repeat serologic testing should be performed in 2–4 weeks to assess for syphilis seroconversion and rule out primary infection. In a patient presumptively treated for primary syphilis whose initial syphilis serology is negative, repeat serologic testing can be performed 2–4 weeks following the initial nonreactive result. Such retesting may detect early seroconversion and if reactive can confirm the syphilis diagnosis as well as establish a baseline titer useful in post-treatment follow-up.

[b] In a patient with no history of syphilis treatment, an isolated reactive RPR could represent partial/early seroconversion. If the patient reports a recent exposure to a syphilis case, presents with a skin lesion suspicious for primary syphilis, has a high nontreponemal test titer (eg, >1:8), or is at increased risk for syphilis, repeat testing in 2–4 weeks might reveal further seroconversion (including reactive treponeme-specific testing). If a patient is at high risk for syphilis and there is a significant risk of loss to follow-up, presumptive treatment could also be considered.



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[b] In a patient with no history of syphilis treatment, an isolated Reactive EIA/CIA could represent partial/early sero-conversion. If the patient reports a recent exposure to a syphilis case, presents with a skin lesion suspicious for primary syphilis, or is at increased risk for syphilis, repeat testing in 2–4 weeks might reveal further seroconversion (including a reactive RPR or TPPA). If a patient is at high risk for syphilis and there is a significant risk of loss to follow-up, presumptive treatment could also be considered.