Washington State Department of Health

DOH 347-656 August 2022

Syphilis

1. DISEASE REPORTING

A. Purposes of Reporting and Surveillance

1. To assess trends in epidemic patterns, understand the impact of the burden of disease on populations and the health care infrastructure, and to better target population-level disease prevention efforts;
2. To assure the adequate treatment of infected individuals in order to reduce the duration of infectiousness and prevent sequelae of infection (e.g., neurosyphilis, gumma); and
3. To identify cases in a timely fashion in order to interrupt the chain of infection through patient-level interventions such as management of sexual contacts and behavioral risk reduction counseling.

B. Legal Reporting Requirements

Washington State Administrative Code (WAC) 246-101 provides an overview of legal reporting requirements for notifiable events in Washington. Important updates to the reporting of patient ethnicity, race, and preferred language information, set to be effective January 1, 2023, can be found at the following link: https://app.leg.wa.gov/WAC/default.aspx?cite=246-101-011

1. Health care providers: notifiable to local health jurisdiction within three (3) work days. Cases should be reported using the Sexually Transmitted Disease (STD) Morbidity Report Form: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CaseReports
2. Hospitals: notifiable to local health jurisdiction within three (3) work days. Cases should be reported using the STD Morbidity Report Form: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/CaseReports
3. Laboratories: notifiable to local health jurisdiction within two (2) work days, specimen submission required to the State Public Health Laboratory: https://www.doh.wa.gov/Portals/1/Documents/Pubs/301-016-PHLDirectoryServices.pdf
4. Local health jurisdictions: notify the Washington State Department of Health (DOH), STD Services Section within 7 days of case investigation completion; summary information required within 21 days for all reported cases. Enter case report information into the Public Health Issue Management System – Sexually Transmitted Disease (PHIMS-STD).

C. Investigation Responsibilities

1. Syphilis cases should be reported to DOH using the PHIMS-STD system to enter investigation information including provider case report, laboratory, interview, and partner management data.
2. Local health jurisdiction staff should initiate an investigation of the index patient within three (3) workdays of receiving a report indicative of syphilis.

3. Local health jurisdiction staff should inform health care providers of the importance of instructing patients to refer sex partners for evaluation and treatment.

2. THE DISEASE AND ITS EPIDEMIOLOGY

A. Etiologic Agent

Treponema pallidum bacterium.

B. Description of Illness

Symptoms of infection are often subtle and easily confused with other sexually transmitted infections, such as genital herpes infection. Untreated, syphilis progresses through stages that are often separated by long periods of latency. Case definitions and laboratory criteria for staging are presented in section three below.

Primary Infection

The primary stage of syphilis infection is usually marked by the appearance of a single sore (chancre), but there may be multiple sores. The time between infection and the onset of symptoms can range from 10 to 90 days (average 21 days). The chancre is usually firm, round, small, and painless. It appears at the spot where syphilis entered the body, generally the genitalia or anus. A primary lesion may also appear in or around the mouth, or, rarely, in other extragenital places depending on exposure. Lymphadenopathy often develops in proximity to the primary lesion. The chancre lasts 1 to 5 weeks (average 3 weeks), and it heals without treatment. However, if appropriate treatment is not administered, the infection progresses to the secondary stage. A person is highly infectious during this stage.

Secondary Infection

Skin rash and mucous membrane lesions characterize the secondary stage. This stage typically starts with the development of a rash on one or more areas of the body. The rash usually does not cause itching. Rashes associated with secondary syphilis can appear as the chancre is healing, or several weeks after the chancre has healed. The characteristic rash of secondary syphilis may appear as rough, red, or reddish-brown spots both on the palms of the hands and the bottoms of the feet. However, rashes with a different appearance may occur on other parts of the body, sometimes resembling rashes caused by other diseases. Sometimes rashes associated with secondary syphilis are so faint that they are not noticed. In addition to rashes, symptoms of secondary syphilis may include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. Mucous patches on mucous membranes, such as in the mouth or vagina, may also appear, as may wart-like lesions called condyloma lata. The signs and symptoms of secondary syphilis will resolve with or without treatment, but without treatment, the infection will progress to the latent and late stages of disease.

Latent Stage

Syphilis infectious is referred to as latent when symptoms are not present. This may occur between primary and secondary phases of the disease, or after secondary symptoms have disappeared. Without treatment, the infected person will continue to have syphilis even though there are no signs or symptoms; infection remains in the body. Latent syphilis is divided into two stages: early non-primary non-secondary and unknown duration or late.

a. *Early Non-Primary Non-Secondary (formerly "Early Latent")*:

This stage applies when an individual is asymptomatic and the earliest date of infection or exposure can be determined to have occurred within a year of diagnosis. In some instances, earliest date of infection can be inferred from a documented negative serologic test result before the current diagnosis, or from onset of documented signs of primary or secondary syphilis.

b. *Unknown Duration or Late*:

This stage applies when an individual is asymptomatic and either the time of infection cannot be determined with certainty *or* the infection occurred more than 12 months prior to diagnosis. If the case remains untreated, late syphilis can persist for the remainder of the person's life.

Clinical Manifestations of Syphilis

Neurologic, ocular, or otic manifestations (neurosyphilis, ocular syphilis, or otosyphilis) can occur during any stage and should be reported along with the appropriate stage.

1. *Neurologic manifestations (Neurosyphilis):* Infection of the central nervous *system* with *T. pallidum*, evidenced by manifestations including syphilitic meningitis, meningovascular syphilis, general paresis including dementia, and tabes dorsalis.
2. *Ocular manifestations (Ocular syphilis):* Infection of the eye with *T. pallidum*, evidenced by manifestations including posterior uveitis, panuveitis, anterior uveitis, optic neuropathy, and retinal vasculitis.
3. *Otic manifestations (Otosyphilis):* Infection of the cochlea and vestibule of the ear with *T. pallidum*, as evidenced by manifestations including sensorineural hearing loss, tinnitus, and vertigo.
4. *Late clinical manifestations (Tertiary syphilis):* Late clinical manifestations typically occur only many years after infection. Approximately 30-40% of untreated persons may develop late clinical manifestations. Manifestations may include inflammatory lesions of the cardiovascular system, skin, bone, or other tissue. Rarely, other internal structures (e.g., upper/lower respiratory tracts, mouth, eye, abdominal organs, reproductive organs, lymph nodes, skeletal muscle) may be involved. Neurological effects such as general paresis and tabes dorsalis are also late clinical manifestations of syphilis.

Congenital Syphilis

Fetal infection occurs with high frequency in untreated early infections of pregnant people and with lower frequency later in latency. It frequently causes spontaneous abortion or stillbirth and may cause infant death due to preterm delivery of low birthweight infants or from generalized systemic disease. Congenital infection may result in late manifestations that include involvement of the central nervous system and may occasionally cause interstitial keratitis or deafness. Congenital syphilis can be asymptomatic, especially in the first weeks of life. See the CDC treatment guidelines for more complete information on the diagnosis and treatment of congenital syphilis: https://www.cdc.gov/std/treatment-guidelines/congenital-syphilis.htm

A CDC Congenital Syphilis Case Investigation and Report form must be completed for all cases in which maternal, infant, or syphilitic stillbirth criteria are met: https://doh.wa.gov/sites/default/files/2022-05/CDC%20Supplemental%20Congenital%20Syphilis%20Form.pdf?uid=62bb4a125a2e8

The Congenital Syphilis Case Investigation and Report form is typically completed by local health jurisdiction or Washington State Department of Health staff. Medical providers may be contacted by LHJ or DOH staff to obtain maternal or infant medical history.

C. Syphilis in Washington State

In recent years, DOH received over 800 reports of primary and secondary syphilis cases per year. Across the last two decades, cases have been found predominately in men who have sex with men (MSM). However, rates of syphilis among cisgender women and men with cisgender female partners have been rising since 2015. The growing number of undiagnosed syphilis infections in cisgender women has likely led to the alarming increase of congenital syphilis cases in recent years. To combat this rising syphilis epidemic, updates to syphilis screening recommendations for some cisgender women and men who have sex with women were released in May 2022. Medical providers and public health professionals may access the updated guidelines from the following medical provider letter:

https://doh.wa.gov/sites/default/files/2022-05/150-163_Congenital_syphilis_letter_to_providers_5.12.2022.pdf?uid=6285168369f2f.

To view the most recent morbidity information on reported syphilis cases in Washington State, see https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease/MorbidityReports.

D. Reservoir

Humans.

E. Modes of Transmission

Syphilis is passed from person to person through direct contact with infectious exudates from obvious or concealed, moist, early lesions of skin and mucous membranes of infected people during sexual contacts. Exposure almost always occurs during oral, anal, or vaginal intercourse. A pregnant woman with the disease can pass it to her unborn child in utero or during delivery.

F. Incubation Period

10 days to 3 months (average 3 weeks).

G. Period of Communicability

Syphilis is transmissible whenever moist mucocutaneous lesions are present. The distinction between the infectious primary and secondary stages and the noninfectious latent stage of syphilis is somewhat arbitrary with regard to communicability, since primary- and secondary-stage lesions may not be apparent to the infected individual.

Lesions of secondary syphilis may recur with decreasing frequency up to 4 years after

infection, but transmission of infection is rare after the first year.

Transmission of syphilis from mother to fetus is most probable during early maternal syphilis but can occur throughout the latent period. Infected infants may have moist mucocutaneous lesions that are more widespread than in adult syphilis and are a potential source of infection when those lesions are present.

Treatment

Treatment options include benzathine penicillin G and doxycycline. See full CDC treatment guidelines: https://www.cdc.gov/std/treatment-guidelines/

3A. CASE DEFINITIONS: Primary Syphilis

A. Clinical Criteria for Diagnosis

A stage of infection with *Treponema pallidum* characterized by one or more chancres (ulcers); chancres might differ considerably in clinical appearance.

B. Laboratory Criteria for Diagnosis

1. Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, direct fluorescent antibody (DFA-TP), or equivalent methods, **OR**
2. Reactive nontreponemal blood test (Venereal Disease Research Laboratory [VDRL] or rapid plasma reagin [RPR]) and a reactive treponemal blood test (enzyme immunoassay [EIA], fluorescent treponemal antibody absorbed [FTA-ABS], or *Treponema pallidum* particle agglutination [TP-PA]).

C. Case Definition

Probable: a clinically compatible case with one or more ulcers (chancres) consistent with primary syphilis and a reactive serologic test (nontreponemal: VDRL or RPR; treponemal: EIA, FTA-ABS, or TP-PA).
Confirmed: a clinically compatible case that is laboratory confirmed.

3B. CASE DEFINITIONS: Secondary Syphilis

A. Clinical Criteria for Diagnosis

A stage of infection caused by *T. pallidum* and characterized by localized or diffuse mucocutaneous lesions, often with generalized lymphadenopathy. Other signs may include mucous patches, condyloma lata, and alopecia. The primary chancre may still be present.

B. Laboratory Criteria for Diagnosis

Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, DFATP, or equivalent methods. Reactive nontreponemal blood test (RPR or VDRL) and a reactive treponemal blood test (EIA, FTA-ABS, or TP-PA).

C. Case Definition

Probable: a clinically compatible case with a nontreponemal (VDRL or RPR) titer ≥ 1:4.

Confirmed: a clinically compatible case that is laboratory confirmed.

3C: CASE DEFINITIONS: Early Non-Primary Non-Secondary (Latent) Syphilis

A. Clinical Criteria for Diagnosis

Latent syphilis is an infection caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs. The early non-primary non-secondary subcategory is diagnosed when the initial infection has occurred within the previous 12 months and there are no signs or symptoms of primary or secondary syphilis.

B. Laboratory Criteria for Diagnosis

No past diagnosis of syphilis, a reactive nontreponemal blood test (RPR or VDRL) and a reactive treponemal blood test (EIA, FTA-ABS, or TP-PA), **OR**

A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer, unless there is evidence that the increase was not sustained for more than 2 weeks.

C. Case Definition

Probable: no clinical signs or symptoms of syphilis and evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:

1. Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months, or
2. A history of symptoms consistent with primary or secondary syphilis during the past 12 months, or
3. A history of sexual exposure to a partner who had confirmed or probable primary or secondary syphilis or probable early non-primary non-secondary syphilis (documented independently as duration < 1 year), or
4. Reactive nontreponemal and treponemal tests from a person whose only possible exposure occurred within the preceding 12 months.

Confirmed: cannot be confirmed.

3D: CASE DEFINITIONS: Unknown Duration or Late Syphilis

A. Clinical Criteria for Diagnosis

A stage caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs. The unknown duration or late subcategory is diagnosed when the initial infection has occurred greater than one year previously, or when there is insufficient evidence to conclude that infection was acquired during the previous 12 months.

B. Laboratory Criteria for Diagnosis

No past diagnosis of syphilis, a reactive nontreponemal blood test (RPR or VDRL), and a reactive treponemal blood test (EIA, FTA-ABS, or TP-PA), **OR**

A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer, unless there is evidence that this increase was not sustained for more than 2 weeks, **OR**

Clinical signs or symptoms and laboratory results that meet the likely or verified criteria for neurologic, ocular, otic, or late clinical manifestations of syphilis.

C. Case Definition

Probable: latent syphilis in a patient who has no evidence of having acquired the disease within the preceding 12 months, or where there is insufficient evidence to conclude that infection was acquired during the previous 12 months.

Confirmed: cannot be confirmed.

3E: CASE DEFINITIONS: Late Clinical Manifestations of Syphilis (Tertiary Syphilis)

A. Clinical Criteria for Diagnosis

Late clinical manifestations of syphilis (tertiary syphilis) other than neurosyphilis may include inflammatory lesions of the cardiovascular system, skin, bone, or other tissue, in the absence of other known causes of these abnormalities. Rarely, other structures may be involved. Late syphilis usually becomes clinically manifest only after a period of 15-30 years of untreated infection.

B. Laboratory Criteria for Diagnosis

A reactive treponemal blood test (EIA, FTA-ABS, or TP-PA), **OR**

Demonstration of *T. pallidum* in late lesions by fluorescent antibody or special stains (although organisms are rarely visualized in late lesions).

C. Case Definition

Likely: reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods)

and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) with either of the following:

1. Characteristic abnormalities or lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue, in the absence of other known causes of these abnormalities,
2. Clinical signs and symptoms consistent with late neurologic manifestations of syphilis (e.g., general paresis, including dementia, or tabes dorsalis) in a case that meets the criteria for likely neurologic manifestations of syphilis.

Verified: reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods) and a reactive treponemal test (e.g., TP-PA, EIA, CIA or equivalent serologic methods) and either of the following:

1. Characteristic abnormalities or lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue in the absence of other known causes of these abnormalities, in combination with

either demonstration of *T. pallidum* in late lesions by special stains or equivalent methods, or by polymerase chain reaction (PCR) or equivalent direct molecular methods, or demonstration of pathologic changes that are consistent with *T. pallidum* infection on histologic examination of late lesions, or

2. Clinical signs and symptoms consistent with late neurologic manifestations of syphilis (e.g., general paresis, including dementia, or tabes dorsalis) in a case that meets the criteria for verified neurologic manifestations of syphilis (see above).

3F: CASE DEFINITIONS: Neurologic Manifestations of Syphilis (Neurosyphilis)

Neurosyphilis can occur at almost any stage of syphilis. Therefore, if the patient has verified or likely neurosyphilis, the case should be reported as the appropriate stage of syphilis and the neurological manifestations should be noted.

A. Clinical Criteria for Diagnosis

Evidence of central nervous system infection with *T. pallidum,* including syphilitic meningitis, meningovascular syphilis, general paresis, including dementia, and tabes dorsalis.

B. Laboratory Criteria for Diagnosis

A reactive serologic test for syphilis and a reactive VDRL in CSF, in the absence of grossly bloody contamination of the CSF.

C. Case Definition

Possible: syphilis of any stage and clinical symptoms or signs that are consistent with neurosyphilis without other known causes for these clinical abnormalities.

Likely: syphilis of any stage, and BOTH of the following:

1. Elevated CSF protein or leukocyte count in the absence of other known causes of these abnormalities.
2. Clinical symptoms or signs consistent with neurosyphilis without other known causes for these clinical abnormalities.

Verified: syphilis of any stage that meets both clinical and laboratory criteria for neurosyphilis.

Ocular syphilis can occur at almost any stage of syphilis. Therefore, if the patient has verified or likely ocular syphilis, the case should be reported as the appropriate stage of syphilis and the ocular manifestations should be noted.

3G: CASE DEFINITIONS: Ocular Manifestations of Syphilis (Ocular Syphilis)

A. Clinical Criteria for Diagnosis

Evidence of infection of any eye structure with *T. pallidum*, including posterior uveitis, panuveitis, anterior uveitis, optic neuropathy, and retinal vasculitis. Ocular syphilis may lead to decreased visual acuity including permanent blindness.

B. Laboratory Criteria for Diagnosis

A reactive serologic test for syphilis and demonstration of *T. pallidum* in aqueous or vitreous fluid by darkfield microscopy, or by polymerase chain reaction (PCR) or equivalent direct molecular methods.

C. Case Definition

Possible: syphilis of any stage and clinical symptoms or signs that are consistent with ocular syphilis without other known causes for these clinical abnormalities.

Likely: syphilis of any stage, and BOTH of the following:

1. Findings on exam by an ophthalmologist that are consistent with ocular syphilis without other known causes for these clinical abnormalities.

2. Clinical symptoms or signs consistent with ocular syphilis without other known causes for these clinical abnormalities.

Verified: syphilis of any stage that meets both clinical and laboratory criteria for ocular syphilis.

3H: CASE DEFINITIONS: Otic Manifestations of Syphilis (Otosyphilis)

Otosyphilis can occur at almost any stage of syphilis. Therefore, if the patient has verified or likely ocular syphilis, the case should be reported as the appropriate stage of syphilis and the otic manifestations should be noted.

A. Clinical Criteria for Diagnosis

Evidence of infection of the cochleovestibular system with *T. pallidum*, including sensorineural hearing loss, tinnitus, and vertigo.

B. Laboratory Criteria for Diagnosis

A reactive serologic test for syphilis and demonstration of *T. pallidum* in inner ear fluid by darkfield microscopy, or by PCR or equivalent direct molecular detection techniques.

C. Case Definition

Possible: syphilis of any stage and clinical symptoms or signs that are consistent with otosyphilis without other known causes for these clinical abnormalities.

Likely: syphilis of any stage, and BOTH of the following:

1. Findings on exam by an otolaryngologist that are consistent with otosyphilis without other known causes for these clinical abnormalities

2. Clinical symptoms or signs consistent with otosyphilis without other known causes for these clinical abnormalities.

Verified: syphilis at any stage that meets both clinical and laboratory criteria for otosyphilis.

3I: CASE DEFINITIONS: Congenital Syphilis

A. Clinical Criteria for Diagnosis

A condition caused by infection in utero with *T. pallidum*. A wide spectrum of severity exists, and only severe cases are clinically apparent at birth. An infant or child (aged <2 years) may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (nonviral hepatitis), pseudoparalysis, anemia, or edema (nephrotic syndrome and/or malnutrition). An older child may have stigmata (e.g., interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints).

Syphilitic stillbirth is a fetal death that occurs after a 20-week gestation or in which the fetus weighs >500 grams and the mother had untreated or inadequately treated (any nonpenicillin therapy or penicillin administered <30 days before delivery) syphilis at delivery. Syphilitic stillbirths are reported as a congenital syphilis case.

B. Laboratory Criteria for Diagnosis

Demonstration of *T. pallidum* by darkfield microscopy, fluorescent antibody, or other specific stains in specimens from lesions, placenta, umbilical cord, or autopsy material.

Reactive nontreponemal blood test (RPR or VDRL) and a reactive treponemal blood test (EIA, FTA-ABS, or TP-PA).

C. Case Definition

Presumptive: a condition affecting an infant whose mother had untreated or inadequately treated (any nonpenicillin therapy or penicillin administered <30 days before delivery) syphilis at delivery, regardless of signs in the infant, or an infant or child who has a reactive treponemal test for syphilis and any one of the following:

1. Any evidence of congenital syphilis on physical examination,
2. Any evidence of congenital syphilis on radiographs of long bones,
3. A reactive cerebrospinal fluid VDRL test,
4. An elevated CSF cell count or protein (without other cause),
5. A reactive fluorescent treponemal antibody absorbed – 19S-immunoglobulin M (IgM) antibody test, or
6. A reactive IgM enzyme-linked immunosorbent assay.

Confirmed: a case that is laboratory confirmed by the methods listed above.

Congenital and acquired syphilis may be difficult to distinguish when a child is seropositive after infancy. Signs of congenital syphilis may not be obvious, and stigmata may not yet have developed. Abnormal values for CSF VDRL, cell count, and protein, as well as IgM antibodies, may be found in either congenital or acquired syphilis.

Findings on radiographs of long bones may help because radiographic changes in the metaphysis and epiphysis are considered classic signs of congenitally acquired syphilis. The decision may ultimately be based on maternal history and clinical judgment. In a young child, the possibility of sexual abuse should be considered as a cause of acquired rather than

congenital syphilis, depending on the clinical picture.

4. DIAGNOSIS AND LABORATORY SERVICES

A. Diagnosis

Demonstration of *T. pallidum* by darkfield microscopy, fluorescent antibody, or other specific stains in specimens from lesions, placenta, umbilical cord, or autopsy material. Reactive nontreponemal blood test (RPR or VDRL) and treponemal blood test (EIA or TP-PA).

B. Tests Available at PHL

The Syphilis Serology Unit at the Washington State Public Health Laboratory (PHL) serves primarily as the Washington State reference laboratory for the confirmation of sera results that are reactive by any serological test for syphilis. The screening enzyme immunoassay (EIA) test is performed on all sera and spinal fluids submitted to the Syphilis Serology Unit.

If the result is reactive, the rapid plasma reagin (RPR) test is performed. If the RPR is non-reactive, a reflexive confirmatory test that is specific for *T. pallidum* antibody (*T. pallidum* particle agglutination, TP-PA) is performed.

The RPR and TP-PA tests are not routinely performed on sera that are non-reactive.

Exceptions can be made but must be communicated to the Syphilis Serology Unit by checking the Reference box on the requisition slip.

The VDRL is used to evaluate the results of treatment therapy as it tends to revert to a lower titer or non-reactive after treatment. The treponemal blood test (EIA, TP-PA) will likely remain positive after treatment.

C. Criteria for Testing at PHL

All reactive serologies (RPR, VDRL, EIA) must have a subsample submitted to the State Public Health Laboratory for a confirmatory test.

D. Specimen Transport

See the Washington State laboratory web page for information on specimen mailing instructions: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthLaboratories/Shipping

E. Evaluate the Diagnosis

The diagnosis should be made with the criteria listed in case definitions above.

5. ROUTINE CASE INVESTIGATIONS

A. Identify Source of Infection

Health department staff should attempt to interview all (100%) early cases of syphilis (primary, secondary and early latent staged). Where staff capacity limits the ability to reach this ideal, staff should focus on maximizing opportunities for intervention in spread of disease. Primary and secondary cases, and cases of syphilis in pregnant women, present the most

obvious opportunities in this regard. Additionally, cases of syphilis diagnosed in people living with HIV who are not virally suppressed or not currently receiving medical care for HIV present high-profile opportunities for intervention in the spread of both syphilis and HIV. Case investigation should be initiated within three (3) working days after the receipt of newly documented positive results on all primary, secondary, and early latent cases. Initiation of a case investigation means that the medical provider has already been contacted or medical record reviewed to ascertain patient symptoms and treatment, and attempts are being made to contact the diagnosed patient for interview. The goal of partner elicitation is to obtain sufficient information to confidentially locate, notify, and refer the partners or suspects for necessary examination, treatment (if appropriate), and risk reduction counseling. In-person interview is the preferred methodology, but telephone interview is also acceptable.

Anyone attempting a syphilis interview should follow the CDC Guidelines for these interviews which can be found at: http://www.cdc.gov/std/program/partners.pdf

B. Managing Potentially Exposed Persons

All sexual contacts who were exposed to a patient diagnosed with early syphilis 90 days or fewer prior to the interview of the index patient may be in the incubation period. These contacts should be tested and treated regardless of positive or negative syphilis test result. Sexual contacts exposed over 90 days prior to the interview of the index patient should be provided a syphilis serology test and treated if that test is positive. Attempts to notify exposed partners or other contacts identified in a patient interview should begin within 24.

hours after identifying information has been obtained by the disease intervention specialist. See above CDC link for management of exposed persons.

C. Environmental Evaluation

Not applicable.

6. CONTROLLING FURTHER SPREAD

A. Infection Control Recommendations

1. Health care setting: Standard Precautions are a set of protocols designed to reduce the risk of (or prevent) transmission of pathogens. Standard precautions synthesize the major features of Universal (Blood and Body Fluid) Precautions (designed to reduce the risk of transmission of bloodborne pathogens) and Body Substance Isolation (designed to reduce the risk of transmission of pathogens from moist body substances). Under standard precautions blood, all body fluids, and all body substances of patients are considered potentially infectious (CDC, 1997). For more information, see CDC Program Guidelines: http://www.cdc.gov/std/program/med&lab.pdf

2. General: When used consistently and correctly, condoms are effective in preventing the sexual transmission of STDs.

B. Case Management

See routine case investigation in Section 5 above.

C. Contact Management

See routine case investigation in Section 5 above.

D. Environmental Measures

None applicable.

7. MANAGING SPECIAL SITUATIONS

Special considerations should be followed in accordance with the CDC diagnostic and treatment guidelines at: https://www.cdc.gov/std/tg2015/default.htm

Call the DOH Infectious Disease Mainline for special situations (360-236-3444), or reach out to your regional Infectious Disease Field Services point of contact:

https://www.doh.wa.gov/AboutUs/ProgramsandServices/DiseaseControlandHealthStatistics/InfectiousDisease/SexuallyTransmittedDiseaseStaff

8. ROUTINE PREVENTION

A. Vaccine Recommendations

No vaccine currently exists for syphilis.

B. Prevention Recommendations

Key individual STD prevention messages include:

Abstinence

Abstain from sex (do not have oral, anal, or vaginal sex) until you are in a relationship with only one person, are having sex with only each other, and each of you knows the other's STD, including HIV, status.

If you have, or plan to have, more than one sex partner:

- ✓ Use a latex condom and lubricant every time you have sex.
- ✓ Get tested for asymptomatic STDs including HIV.
- ✓ If you are a man who has had sex with other men, get tested at least once a year.
- ✓ If you are a woman who is planning to get pregnant or who is pregnant, get tested for syphilis and HIV as soon as possible, before you have your baby. Ask your health care provider about being tested for other STDs.
- ✓ Talk about STDs, including HIV, with each partner before you have sex.
- ✓ Learn as much as you can about each partner's past behavior (sex and drug use).
- ✓ Ask your partners if they have recently been treated for an STD or have been tested for HIV; encourage those who have not been tested to do so.

Key STD prevention strategies include:

STD prevention counseling, testing, and referral services – Individuals at risk for STD should be offered counseling regarding methods to eliminate or reduce their risk and testing so that they can be aware of their status and take steps to protect their own health and that of their partners.

Partner Services (or Partner Notification) with strong linkages to prevention and treatment/care services – Sexual partners of STD-infected persons have been exposed to an STD and are at-risk of being infected. Partner services locate these individuals based on information provided by the patient and provide counseling and education about the exposure as well as services to prevent infection or, if infected, linkages to care.

Prevention for high-risk populations – Prevention interventions for high-risk populations at high-risk for STDs, including HIV-infected persons, are critical to reducing the spread of STDs and HIV and ensure that those at highest risk of acquiring or transmitting these diseases are given the tools necessary to protect themselves and others from HIV infection. Prevention includes targeted health education and risk reduction, health communication programs, and public information programs for at-risk populations and the general public.

HIV Prevention and Care – For people at high risk of acquiring HIV, which may include for example some MSM patients and some people who inject drugs, referral to HIV testing (if HIV status is not already known) and referral to PrEP (Pre-exposure Prophylaxis for HIV) navigation or evaluation is key in preventing acquisition of HIV.

For people living with HIV who are not receiving medical care or who are not virally suppressed, referral to HIV case management and medical care for HIV infection are key in promoting individual health as well as preventing spread of HIV. More information about PrEP for HIV in Washington State can be found here: https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/Prevention/PrEP

School-based STD Prevention – Schools have a critical role to play in promoting the health and safety of young people and helping them establish lifelong healthy behavior patterns. Washington State requires schools to teach medically accurate comprehensive sex education if such is provided by the school district.

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For persons with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 1-800-833-6388).