State of Montana *Health Alert Network*

DPHHS HAN HEALTH UPDATE

Cover Sheet

DATE: March 13, 2018

SUBJECT: Continued Syphilis Transmission in Montana, Including increasing impact on Women

INSTRUCTIONS:

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For LOCAL HEALTH DEPARTMENT reference only

DPHHS Subject Matter Resource for more information regarding this HAN, contact:

DPHHS CDCP
STD/HIV
406-444-3565

DPHHS Health Alert Hotline: 1-800-701-5769

DPHHS HAN Website:
www.han.mt.gov

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Categories of Health Alert Messages:

Health Alert: conveys the highest level of importance; warrants immediate action or attention.

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Health Update: provides updated information regarding an incident or situation; unlikely to require immediate action.

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State of Montana ***Health Alert Network***

DPHHS HAN

Information Sheet

Date: March 13, 2018

Subject: Continued Syphilis Transmission in Montana, Including increasing impact on Women

Background: Local and state public health officials are continuing to see a significant increase in syphilis activity in Montana. As of March 12, 2018, 9 cases of primary and secondary syphilis have been reported, compared to an average of 12 cases reported annually during non-outbreak years. The majority are in Yellowstone County, but Cascade, Gallatin and Lewis & Clark Counties have also reported one case each.

Of these nine, four are females of childbearing age and include one pregnancy. Health care providers are encouraged to continue efforts to assess sexual health risks of patients, particularly pregnant women, and provide appropriate testing and treatment in addition to promptly reporting cases to local public health authorities.

Information: Clinicians can assist by assessing risks and testing for syphilis during first prenatal visit, and subsequent visits depending upon risk, as well as during routine women's health exams. Routine testing is recommended for:

- men who have sex with men (MSM),
- pregnant women,
- persons who have HIV infection,
- persons who have partner(s) who have tested positive for syphilis,
- any person with high risk sexual behavior such as multiple concurrent partners, anonymous sex, sex while high or intoxicated, and women whose partners are men who have sex with men (MSM).

Additional recommendations regarding screening, diagnosis, treatment, and required reporting for pregnant women are found in the attachment, and below are recommendations for local public health as well as links to additional resources.

Testing:

Nontreponemal tests commonly used for initial screening include:

- ☐ Venereal Disease Research Laboratory test (VDRL)
- ☐ Rapid plasma regain test (RPR)

Note: Quantitative tests (titers) generally reflect the activity of the infection.

Confirmatory tests include:

- ☐ *Treponemal pallidum* particle agglutination test (TP-PA)
- ☐ Fluorescent treponemal antibody absorbed test (FTA-ABS)
- ☐ *T. pallidum* enzyme immunoassay antibody test (TP-EIA)
- ☐ Chemiluminescence immunoassay (CIA)

Note: As a group, these tests are based upon the detection of antibodies directed against specific treponemal antigens. Treponemal tests are qualitative only and are reported as "reactive" or nonreactive"

Reporting:

Reporting of suspected and confirmed cases of syphilis *is required by state reporting rules*. Public health authorities are required to ensure proper treatment is administered and will conduct contact-tracing efforts to identify partners who may be at risk of infection. Prompt reporting by clinicians is essential to break the disease transmission cycle.

Treatment:

Appropriate treatment is critical to control the spread of infection and required by Montana Administrative Rules. Pregnant women may be treated as soon as infection is identified.

Recommended treatment for Syphilis:

- Recommended regimen for Adults with *Primary, Secondary Syphilis or Early Latent Syphilis*: Benzathine penicillin G 2.4 million units IM in a single dose
- *Late Latent Syphilis or Latent Syphilis of Unknown Duration or Tertiary Syphilis with Normal CSF Examination*: Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals
- Alternatives to the above-recommended treatments are generally used only when patients have demonstrated an allergy to penicillin. CDC guidelines recommend that providers ask patients about known allergies to penicillin. Any person allergic to penicillin should be treated in consultation with an infectious-disease specialist.

Local Health Authorities

- Administrative Rules of Montana (ARM) require the local health officer, or designee, to investigate and implement control measures as indicated by STD Treatment Guidelines to prevent or control the transmission of disease.
- Verify that appropriate treatment has been given to the patient before sending case record form into DPHHS.
- Local health officers are required to report information about a case to DPHHS within the timeframes established in (ARM) 37.114.204. Syphilis must be reported within one business day.

  Note: DPHHS staff will assist local jurisdictions as necessary and monitor each case to assist with treatment and follow-up as needed.

Resources

- Pocket guides for providers on taking a sexual history, syphilis and STD treatment guidelines.
- Details regarding signs and symptoms, testing and treatment can be found on page 34 of the CDC 2015 STD Treatment Guidelines.
- Additional clinical training slides are available at:

- Additional information regarding resources and Montana-specific information can be found at:

Health care providers

The following are recommendations are for Pregnant Women from the CDC 2015 STD Guidelines:

Prevention: Prevent congenital syphilis in newborn babies by treating the infected mother early.

***Patient Assessment/Screening*:**

- All pregnant women at the first prenatal visit
- Retest twice in the third trimester at 28-32 weeks and at delivery, if at high risk (contact to known syphilis case, infection with other sexually transmitted diseases, residence in an area with high syphilis prevalence)
- Any woman who has experienced a fetal demise after 20 weeks should be tested for syphilis
- When syphilis is diagnosed in the second half of pregnancy, management should include a sonographic fetal evaluation for congenital syphilis. Sonographic signs of fetal or placental syphilis (i.e., hepatomegaly, ascites, hydrops, fetal anemia, or a thickened placenta) indicate a greater risk for fetal treatment failure; cases accompanied by these signs should be managed in consultation with obstetric specialists. Evidence is insufficient to recommend specific regimens for these situations.
- All women who have syphilis should be offered HIV testing.

***Follow up*:**

Coordinated prenatal care and treatment are vital. At a minimum, serologic titers should be repeated at 28–32 weeks' gestation and at delivery. Serologic titers can be checked monthly in women at high risk for reinfection or in geographic areas in which the prevalence of syphilis is high. Providers should ensure that the clinical and antibody responses are appropriate for the patient's stage of disease, although most women will deliver before their serologic response to treatment can be assessed definitively. Inadequate maternal treatment is likely if delivery occurs within 30 days of therapy, clinical signs of infection are present at delivery, or the maternal antibody titer at delivery is fourfold higher than the pretreatment titer.

Recommendations for Congenital Syphilis:

The diagnosis of congenital syphilis can be difficult, as maternal nontreponemal and treponemal IgG antibodies can be transferred through the placenta to the fetus, complicating the interpretation of reactive serologic tests for syphilis in neonates. Therefore, treatment decisions frequently must be made on the basis of 1) identification of syphilis in the mother; 2) adequacy of maternal treatment; 3)

presence of clinical, laboratory, or radiographic evidence of syphilis in the neonate; and 4) comparison of maternal (at delivery) and neonatal nontreponemal serologic titers using the same test, preferably conducted by the same laboratory. Any neonate at risk for congenital syphilis should receive a full evaluation and testing for HIV infection (from the).

All neonates born to women who have reactive serologic tests for syphilis should be examined thoroughly for evidence of congenital syphilis such as:

- Nonimmune hydrops
- Jaundice
- Hepatosplenomegaly
- Rhinitis (“snuffles”)
- Pseudoparalysis of an extremity

Pathologic examination of the placenta or umbilical cord using specific staining (e.g. silver) or a *T. pallidum* PCR test should be considered. PCR testing of suspicious lesions or body fluids (such as nasal discharge), should also be performed. *Serum for quantitative nontreponemal tests should not be obtained from cord blood due to potential for false-negative from Wharton’s jelly and false-positive results from maternal blood contamination*. Conducting a treponemal test (i.e. TP-PA, FTA-ABS, EIA, or CIA) on neonatal serum is not recommended because it is difficult to interpret.
No commercially available immunoglobulin (IgM) test can be recommended.

When congenital syphilis is possible, probable or confirmed, serum nontreponemal VDRL titer, cerebrospinal fluid analysis for VDRL, cell counts, and protein, along with a complete blood count (CBC) with differential, and platelet count are recommended.

Treatment and follow-up for congenital syphilis is dependent upon age and when the infection is recognized. Report suspected cases to local public health within one business day. *T. pallidum* PCR testing is available through CDC when requested through local public health.

***Treatment*:**

Appropriate treatment is critical to control the spread of infection and required by Montana Administrative Rules. Treat syphilis in pregnant women as soon as infection is identified with the penicillin regimen appropriate for the stage of infection. Recommended treatment for syphilis:

- Recommended regimen for pregnant women with *Primary, Secondary Syphilis or Early Latent Syphilis*: Benzathine penicillin G 2.4 million units IM in a single dose

- *Late Latent Syphilis or Latent Syphilis of Unknown Duration or Tertiary Syphilis with Normal CSF Examination*: Benzathine penicillin G 7.2 million units total, administered as 3 doses of
  2.4 million units IM each at 1-week intervals. Skipped doses are unacceptable for pregnant women. Pregnant women who miss doses must repeat the full course of therapy.
- *No proven alternatives to penicillin are available for treatment of syphilis during pregnancy. Pregnant women who have a history of penicillin allergy should be desensitized and treated with penicillin. Skin testing or oral graded penicillin dose challenge might be helpful in identifying women at risk for acute allergic reactions.*
- Some evidence suggests that additional therapy is beneficial for pregnant women. For women who have primary, secondary or early latent syphilis, a second dose of benzathine penicillin 2.4 million units IM can be administered 1 week after the initial dose.

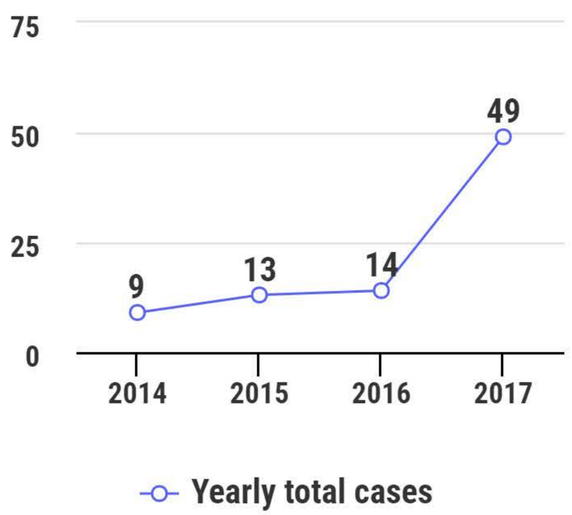
For more information, please consult the.

2018 Syphilis Cases

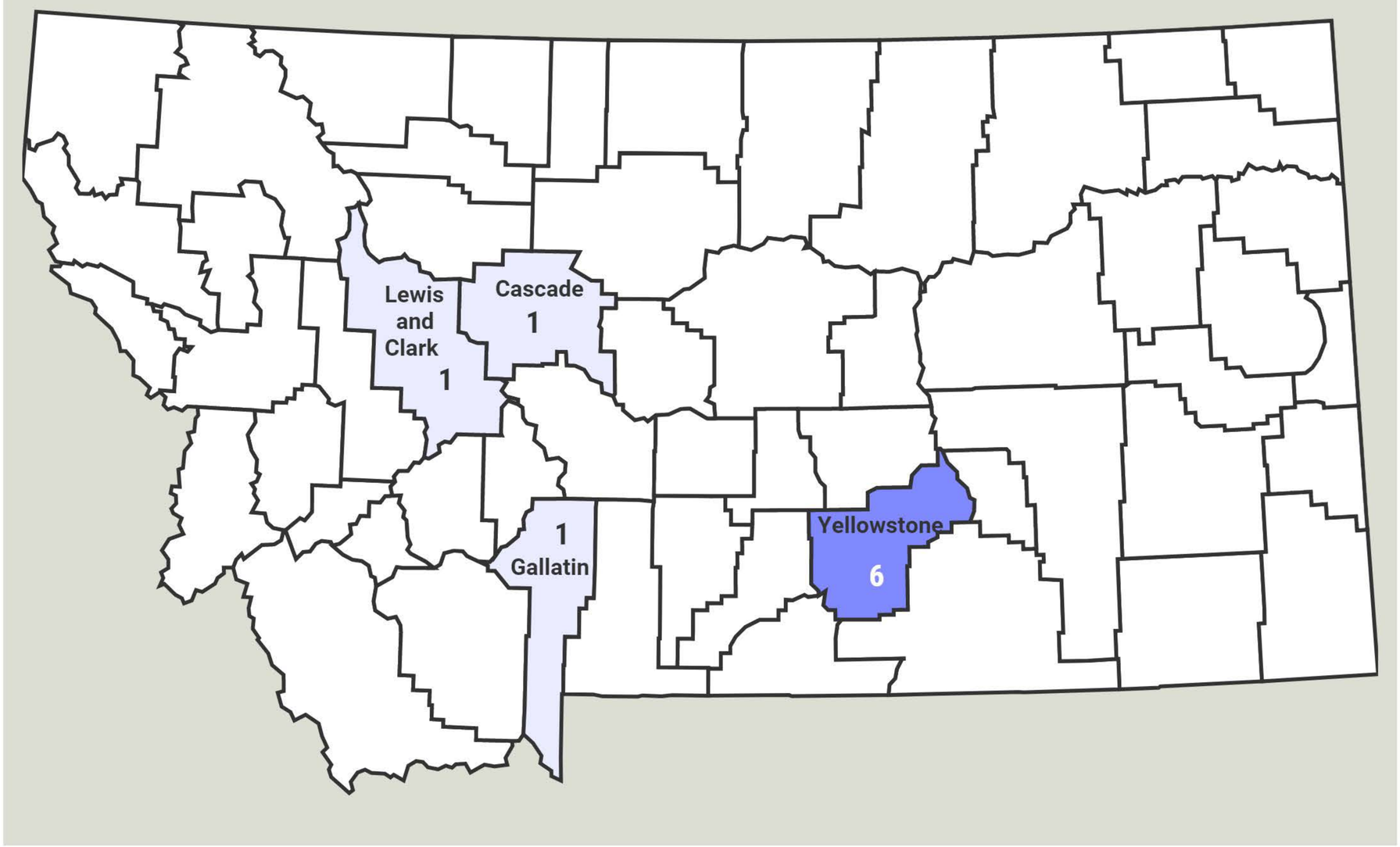
Syphilis cases diagnosed in the primary and secondary stage are infectious and of great concern to public health. The following information characterizes risk factors for syphilis in these stages.

Of greatest concern in 2018 is the number of women of childbearing age diagnosed with syphilis. In 2017, there was a case of congenital syphilis identified.

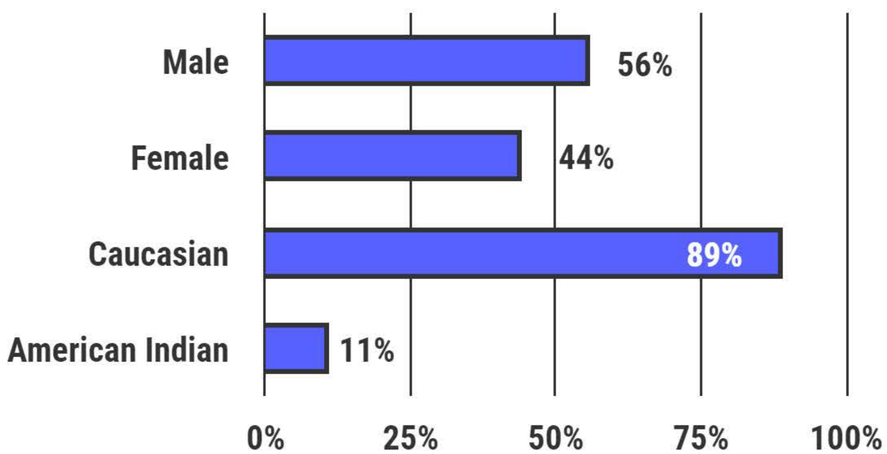
Case counts of primary and secondary syphilis are climbing.



Syphilis-Primary and Secondary, Montana, March 12, 2018



Selected Demographics of 2018 cases



Risk Factors of 2018 Syphilis Cases

100% of female cases were women of childbearing age. One case was pregnant.

SEX 89% of cases involved high risk sexual activity such as multiple partners and anonymous sex.

HIV One case was co-infected with HIV.