Montana Health Alert Network

DPHHS HAN

ADVISORY

Cover Sheet

DATE

July 8, 2020

SUBJECT

Continued syphilis transmission in Montana posing increased threat for women during pregnancy

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 Section
1-406-444-3565

For technical issues related to the HAN message contact the Emergency Preparedness Section at 1-406-444-0919

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

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Health Alert: conveys the highest level of importance; warrants immediate action or attention.
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Information Service: passes along low level priority messages that do not fit other HAN categories and are for informational purposes only.

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BACKGROUND

Local and state public health officials are continuing to see an increase in reported syphilis activity in Montana. In 2019 and 2020, 108 cases of early syphilis (including primary, secondary and early latent syphilis) have been reported and two cases of congenital syphilis. Most cases are in Cascade County, but Yellowstone and Missoula Counties continue to report syphilis as well.

Most cases are reported in men (76%), especially men who have sex with men (48%), but continued transmission of syphilis between men and women poses a threat to women of childbearing age, as syphilis during pregnancy can cause severe complications and birth defects. During this 18-months' time period, 26 females were infected with early syphilis: 96% were of childbearing age and two of them were in fact pregnant, leading to poor pregnancy outcomes. Congenital syphilis has not been reported in Montana for many decades, up until recently when three cases of congenital syphilis have been identified in less than 4 years.

INFORMATION

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. Symptoms spontaneously resolve after the primary and secondary stages and can possibly be difficult to self-identify (i.e. internal vaginal chancres). Therefore, assessing sexual behaviors and routine screening, especially during prenatal visits, becomes particularly important for women.

RECOMMENDATIONS FOR HEALTHCARE PROVIDERS

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 who have sex with MSM.

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

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.

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*. Titers are essential to diagnose syphilis reinfection as the treponemal tests will most likely remain positive for a lifetime for those previously infected.

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. 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 2015 *Sexually Transmitted Diseases Treatment Guidelines, Syphilis During Pregnancy*.
    - https://www.cdc.gov/std/tg2015/syphilis-pregnancy.htm