



Technical Bulletin

Division of Public and Behavioral Health



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Topic: Rising Rates of Congenital Syphilis in Nevada- Call for Action

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To: Health Care Providers, Medical Facilities, OBGYN

CURRENT SITUATION: INCREASING RATES OF CONGENITAL SYPHILIS IN NEVADA

In 2017, Nevada ranked 1st in reported cases of Primary and Secondary Syphilis and 2nd in the nation for Congenital Syphilis. From 2016 to 2018, Nevada has almost tripled the number of reported congenital syphilis cases: 2016-10 cases, 2017-22 cases, 2018-30 cases. While, nationally and in Nevada, the rate of syphilis among males is much higher than women, over the past several years there has been a consistent increasing trend among women.

WHAT IS CONGENITAL SYPHILIS?

Congenital syphilis (CS) is a disease that occurs due to vertical transmission of treponema pallidum when a mother with syphilis passes the infection on to her infant during pregnancy. CS can cause major health impacts to a baby including spontaneous miscarriage, stillbirth, premature delivery, low birth weight, or death shortly after birth. Up to 40% of babies born to women with untreated syphilis may be stillborn or die from the infection as a newborn. Newborn babies with CS can have bone deformities, severe anemia, hepatosplenomegaly, jaundice, blindness, deafness, neuropathy, meningitis, and skin rashes.¹

CONGENITAL SYPHILIS CAN BE PREVENTED!

Congenital syphilis can and should be prevented with early detection; timely and effective treatment of syphilis in pregnant women and women who could become pregnant. Preconception and interconception care should include screening for HIV and sexually transmitted infections (STIs), including syphilis and, Hepatitis B viral infection among women at risk.

RECOMMENDATIONS- TALK, TEST, AND TREAT! Clinicians who may treat pregnant women are strongly advised to review and comply with current CDC recommendations and be aware of the alarming increasing trend in the state of Nevada.

TALK- Routine risk assessment, as well as a thorough sexual history, should be conducted throughout pregnancy to determine risk factors. In addition, it is essential for providers to discuss STIs prevention methods. Advise your patient to tell sexual partner/partners about the infection and encourage them to get tested and treated to avoid reinfection.

WOMEN AT RISK FOR SYPHILIS

- Have signs and symptoms of syphilis infection.
- Live in areas with high rates of syphilis, particularly among females.
- Have a history of syphilis or another STI.
- Receive late or limited prenatal care.
- Did not get tested in the first or second trimester.
- Have partners that may have other partners, or partners with male partners.
- Have history of incarceration.
- Are involved with substance use or exchange sex for money, housing, or other resources.
- Women with history of delivering a stillborn baby

TEST- PRENATAL SCREENING: IT'S THE LAW! In Nevada, it is required by law (NRS 442.010) pregnant women be tested for syphilis at their first prenatal visit and again early in the third trimester (28-32 weeks gestational age). Some women may be in the asymptomatic stage of syphilis. Women who are asymptomatic can still spread the infection to their unborn babies.

- For communities and populations in which the prevalence of syphilis is high such as in several Nevada communities and for women at high risk for infection, serologic testing should also be performed twice during the third trimester, once at 28–32 weeks’ gestation and again at delivery.²
- If a woman of child bearing age tests positive for syphilis, it is important to test for pregnancy as well.
- Syphilis is diagnosed by reviewing patient history, taking a thorough sexual risk assessment, conducting a physical exam, and obtaining blood tests.
- Making the diagnosis of syphilis requires interpretation of **both** treponemal and non-treponemal serology tests results. **In populations in which receipt of prenatal care is not optimal, RPR test screening and treatment (if the RPR is reactive) should be performed at the time pregnancy is confirmed¹.**
- It is important to follow up with the mother to ensure she is aware of her results, treatment plan and risk to her and the baby if syphilis is left untreated.
- Screening for syphilis in nonpregnant populations is an important public health approach to preventing the sexual transmission of syphilis and subsequent vertical transmission of congenital syphilis. The USPSTF recommends also screening for syphilis in nonpregnant adolescents and adults at increased risk for infection.⁴

TREAT- If your patient is diagnosed with syphilis, take immediate action. All pregnant women diagnosed with syphilis should be treated immediately according to CDC’s 2015 [STD treatment guidelines²](https://www.cdc.gov/std/tg2015/default.htm). **Treatment at least 30 days before delivery is likely to prevent congenital syphilis.**

Treatment for a pregnant woman is based on the stage of her infection.

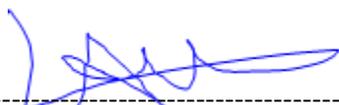
Treatment for Early Syphilis (determined to be less than one year's duration)	Treatment for Late Latent Syphilis or Unknown Duration
Benzathine penicillin G 2.4 million units by intramuscular injection in a single dose	Benzathine penicillin G 2.4 million units by intramuscular injection every 7 days for 3 weeks (7.2 million units total)

In pregnancy, penicillin is the only recommended therapy. Pregnant women with penicillin allergies should be properly desensitized and treated with penicillin. There are no alternatives.

- **Before discharging any newborn infant from the hospital, ensure the mother has been tested for syphilis at least once during her pregnancy or at delivery.** If the test is positive, ensure that the mother and baby are evaluated appropriately before discharge and, if necessary, treated. Any woman who delivers a stillborn infant (greater than 20 weeks or 500g) should be tested for syphilis.

PARTNER TREATMENT AND THE ROLE OF LOCAL HEALTH DEPARTMENTS

Because sex with an untreated partner can result in **re-infection**, it is especially important to ensure that all sexual partners receive treatment, and to inform pregnant women about the significant risk to their infants if they have sex with an untreated partner. **State and local health departments are key participants in the prevention of congenital syphilis and can assist with partner treatment. In addition, such institutes have the ability to collaborate with other local organizations (e.g. WIC, Medicaid, perinatal substance use programs, Emergency Departments) in addressing barriers to obtaining early and adequate prenatal care for the most vulnerable pregnant women in your community.**



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References:

¹ Centers for Disease Control and Prevention Congenital Syphilis Fact Sheet <https://www.cdc.gov/std/syphilis/stdfact-congenital-syphilis.htm>

² CDC’s 2015 Treatment Guidelines <https://www.cdc.gov/std/tg2015/default.htm>

³ Nevada's Disease Reporting Form:

:[http://dpbh.nv.gov/Programs/OPHIE/dta/Forms/Public_Health_Informatics_and_Epidemiology_\(OPHIE\)_-_Forms/](http://dpbh.nv.gov/Programs/OPHIE/dta/Forms/Public_Health_Informatics_and_Epidemiology_(OPHIE)_-_Forms/) ⁴ US Preventive Services- *Final Recommendation Statement Syphilis Infection in Pregnant Women*

<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/syphilis-infection-in-pregnancy-screening1>