

Syphilis 101

Jacob McLean, DO

Adult Infectious Diseases

Assistant Professor of Medicine at Columbia University Medical Center

NYC STD Prevention Training Center

jm5146@cumc.columbia.edu

Presenter Disclosures

- The author and their spouses/partners wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters.

PTC Disclaimer

Some terms in this presentation may have been modified to align with executive order requirements that this CDC-funded grant has received.

Objectives

1. Recognize the burden of syphilis
2. Identify the stages of syphilis infection
3. Interpret syphilis serologic tests
4. Determine appropriate syphilis treatments by stage
5. Summarize changes in syphilis diagnosis and treatment in special cases

Not covered


- Congenital syphilis
- Syphilis in pregnancy
- Syphilis prevention e.g. Doxy PEP

Bacterial STI Rates: Good News/Bad News

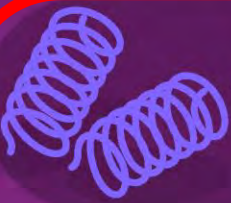

The State of STIs in the U.S. in 2024



Data are provisional. Details: www.cdc.gov/sti-statistics



  **1.5 million** cases of **CHLAMYDIA**; **4% decrease** since 2020.

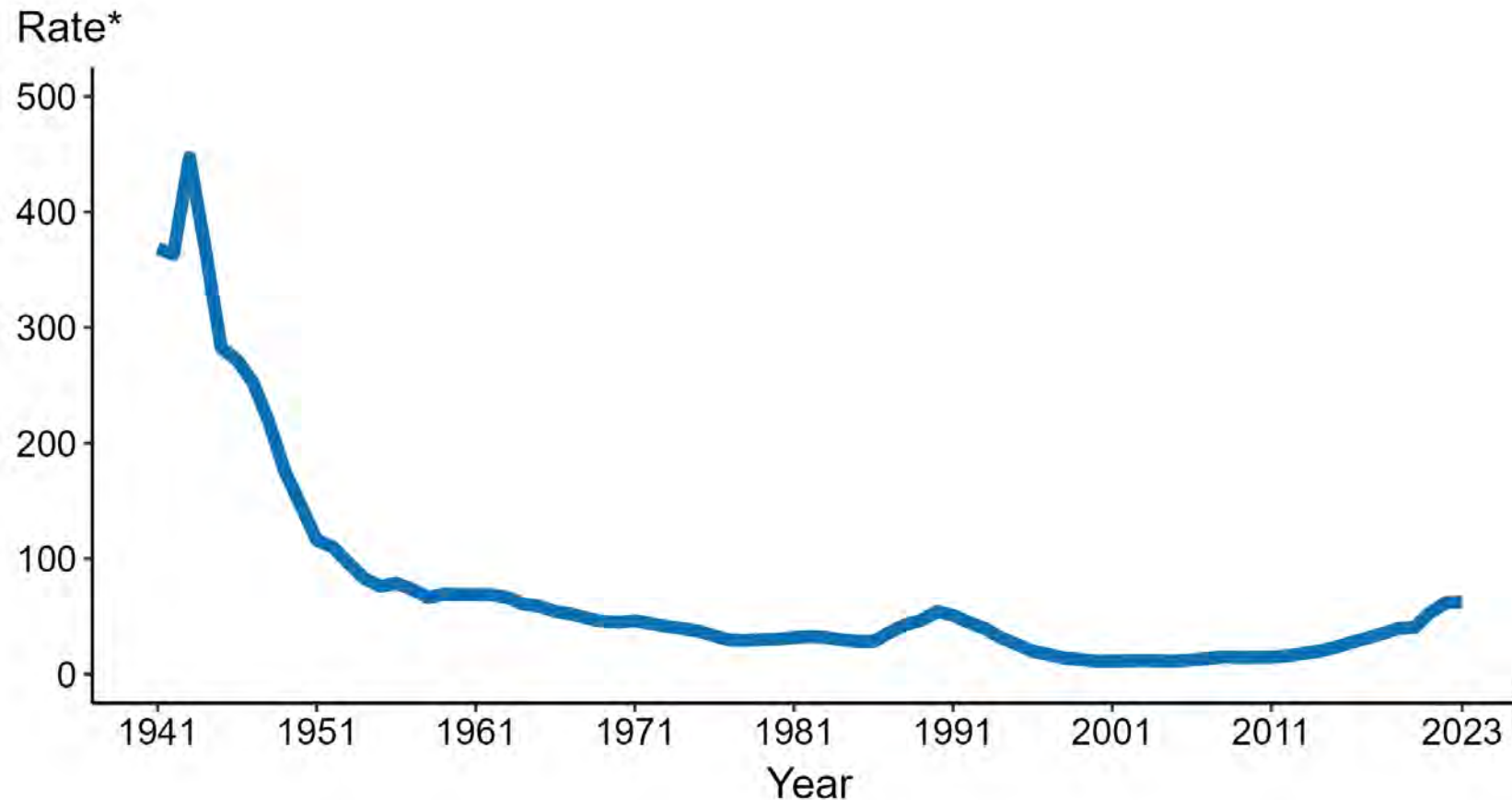
  **543,409** cases of **GONORRHEA**; **20% decrease** since 2020.

  **190,242** cases of **SYPHILIS**; **42% increase** since 2020.

  **3,941** cases of **SYPHILIS AMONG NEWBORNS**; **82% increase** since 2020.

Syphilis: Bouncing Back

Syphilis — Rates of Reported Cases by Year, United States, 1941–2023



* Per 100,000

NOTE: Total syphilis includes all stages of syphilis and congenital syphilis



COLUMBIA

COLUMBIA UNIVERSITY
IRVING MEDICAL CENTER



The National Plan to Eliminate Syphilis

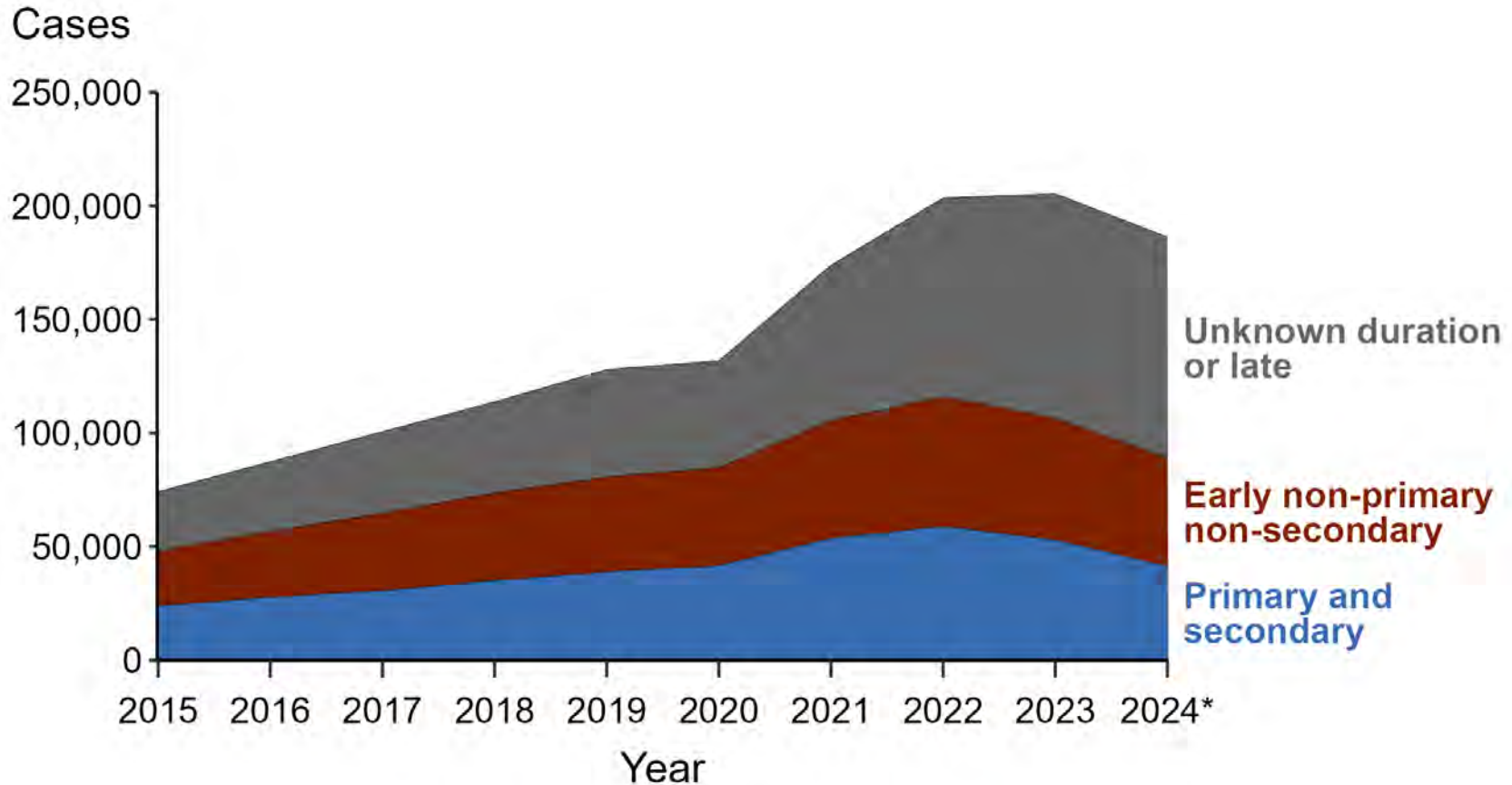
The National Plan to Eliminate Syphilis from the United States

October 1999
Division of STD Prevention
National Center for HIV, STD, and TB Prevention
Centers for Disease Control and Prevention

As we approach the end of the 20th century, the United States is faced with a unique opportunity to eliminate syphilis within its borders. Syphilis is easy to detect and cure, given adequate access to and utilization of care. Nationally, it is at the lowest rate ever recorded and it is confined to a very limited number of geographic areas, primarily in the southern United States. Where syphilis does persist in the U.S., it disproportionately burdens African Americans living in poverty. Syphilis elimination is not only feasible, but also can have far-reaching public health implications by removing its devastating consequences—increased likelihood of HIV transmission and spontaneous abortions, stillbirths, and multi-system disorders caused by congenital syphilis acquired from mothers with syphilis.

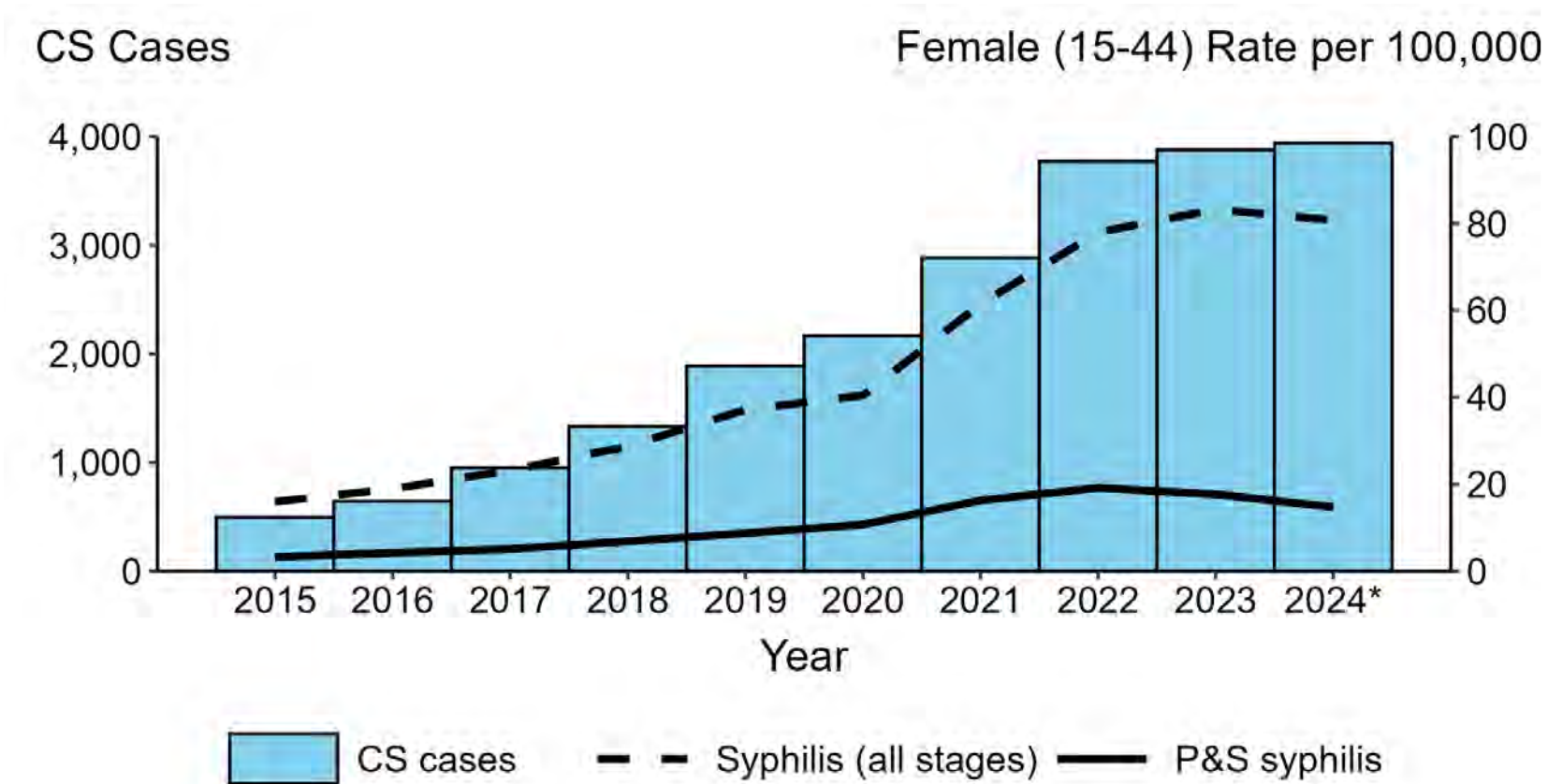
- <https://www.cdc.gov/stopsyphilis/exec.htm>

Syphilis — Reported Cases by Stage and Year, United States, 2015–2024



* 2024 data are provisional as of August 14, 2025.

Congenital Syphilis — Reported Cases by Year of Birth and Rates of Reported Cases of Primary and Secondary Syphilis and Syphilis (All Stages) Among Women Aged 15–44 Years, United States, 2015–2024



* 2024 data are provisional as of August 14, 2025.

ACRONYMS: CS = Congenital syphilis; P&S Syphilis = Primary and secondary syphilis

What Can We Do?

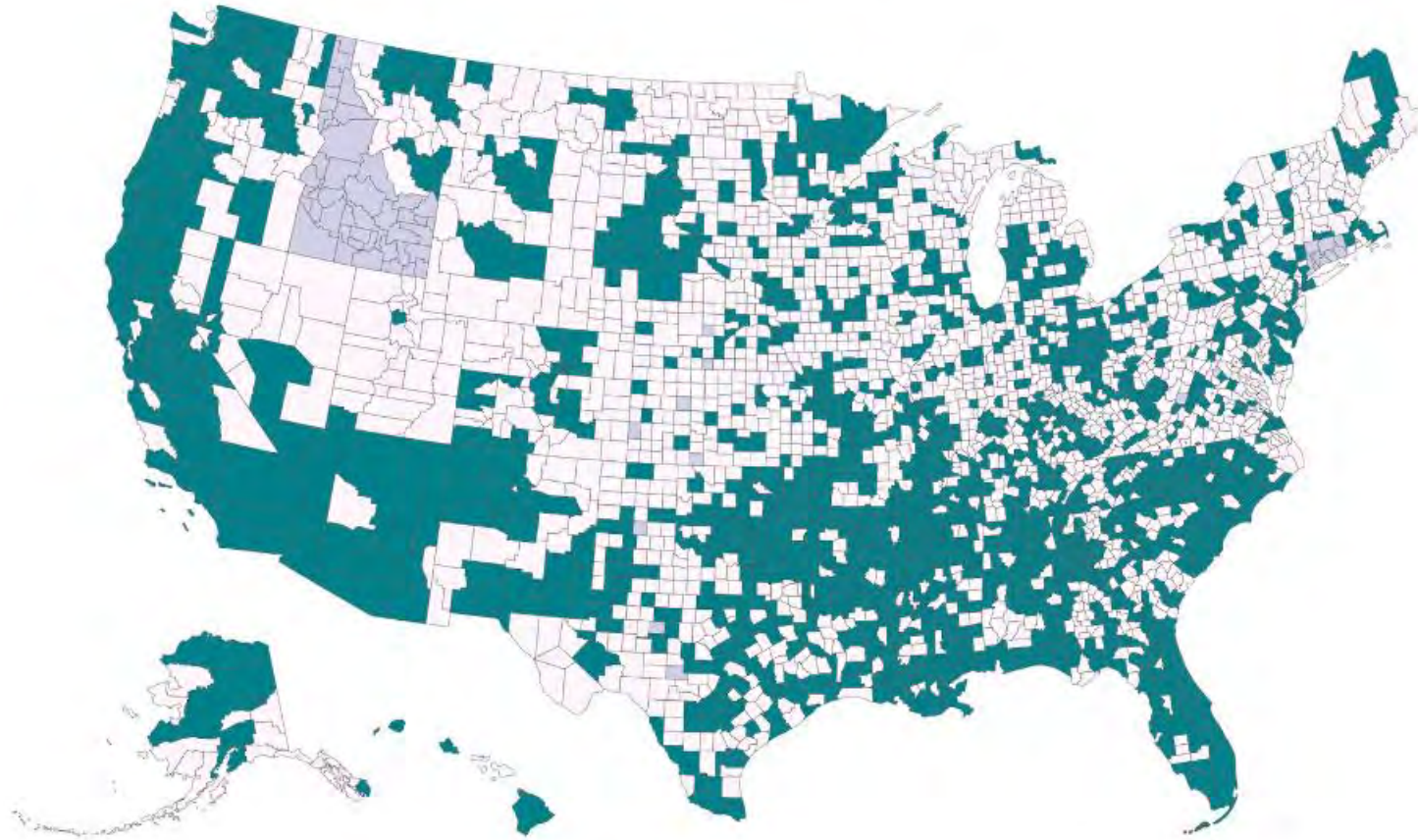


General Screening for Syphilis

Population	Recommendations
Men who have sex with men	<ul style="list-style-type: none"> At least annually if sexually active Every 3-6 months based on increased risk*
Patients taking PrEP	<ul style="list-style-type: none"> At initiation and every 3-6 months if increased risk*
Persons living with HIV	<ul style="list-style-type: none"> At diagnosis and at least annually if sexually active, and more frequently depending on individual risk and local epidemiology*
Non-pregnant Women	<ul style="list-style-type: none"> No national recommendation for routine screening Screen asymptomatic adults at increased risk*
Non-MSM Men	
Pregnant Women	<ul style="list-style-type: none"> First prenatal encounter plus third trimester (28 weeks) and at delivery if increased risk or in a community with increased prevalence***

Workowski KA, Bachmann LH, Chan PA, et al. Sexually Transmitted Infections Treatment Guidelines, 2021. MMWR Recomm Rep. 2021;70(4):1-187. Published 2021 Jul 23. doi:10.15585/mmwr.rr7004a1

Syphilis Rates are High (Almost) Everywhere



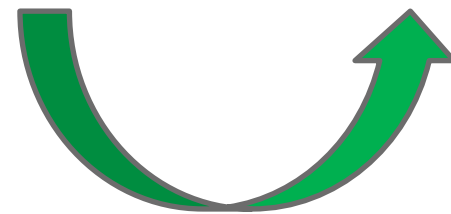
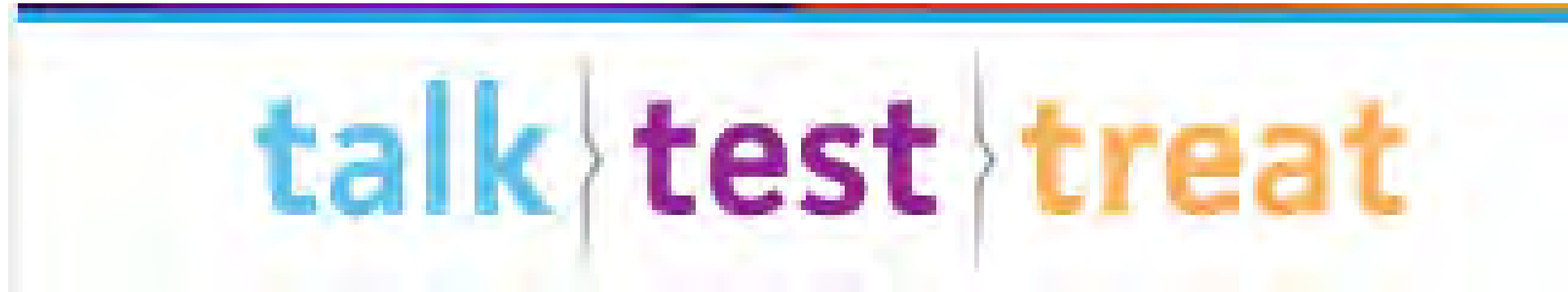
Continue to assess individual risk factors to determine screening needs*
Offer syphilis testing to all sexually active people aged 15-44 years**
Suppressed†

- Counties with syphilis rates >4.6 per 100,000 among females 15-44
- **72%** of the US population

A Case for Increased Screening

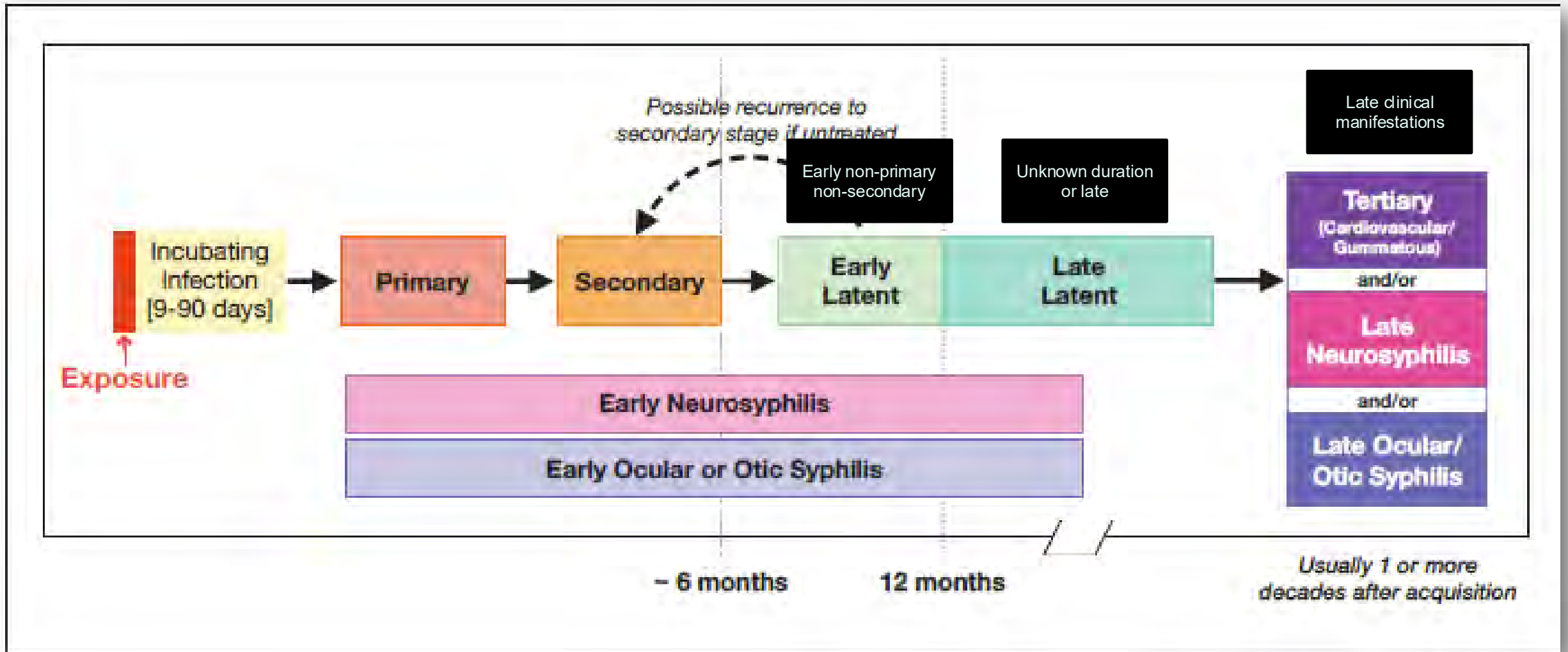
- In 2024, there were 144,805 cases of early non-primary, non-secondary syphilis and late syphilis/unknown duration i.e. “latent” infection
- The same year, there were 41,496 cases of primary or secondary syphilis i.e. symptomatic disease
- A large majority of new syphilis cases are diagnosed in people with no current symptoms
 - Screening is critical for preventing transmission and late complications!

A Missing Step

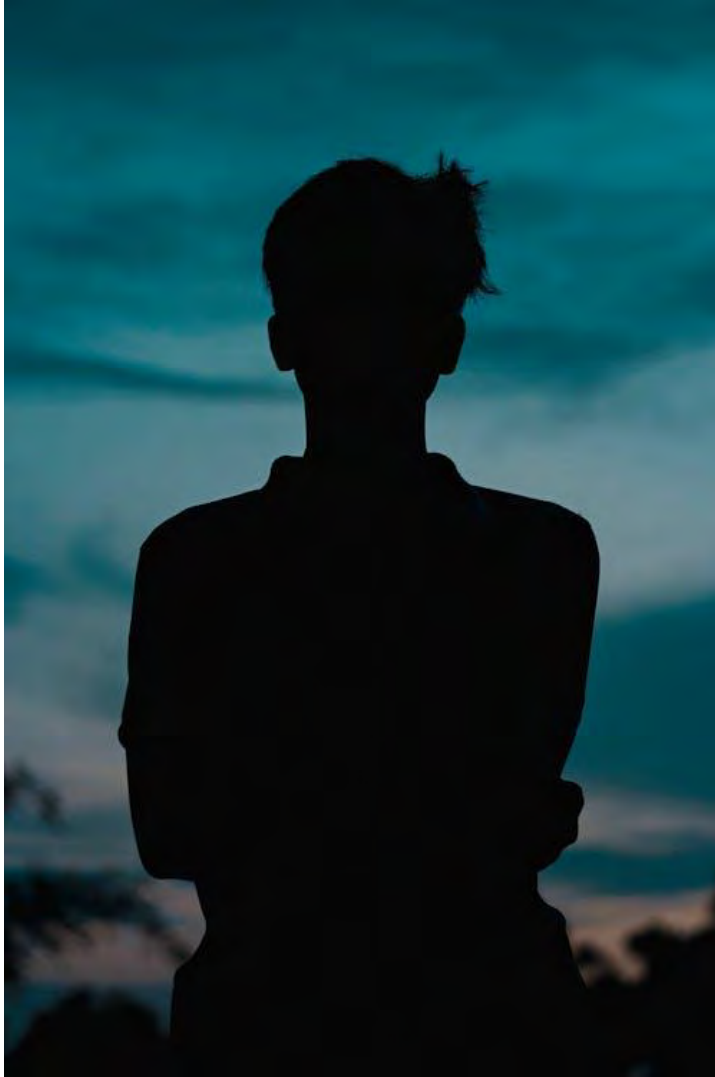


stage

Syphilis – Natural History



Meet Joseph



- 24-year-old bisexual male
- Presents for “an ulcer on my penis”
- “It has been there for a few days but doesn’t hurt”
- On exam had some inguinal lymphadenopathy
- **How to stage Joseph?**

Syphilis – Primary

A stage of infection with *Treponema pallidum* characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance



Syphilis – Primary

- Primary Syphilis
 - **Local**
 - **One or more ulcers (chancres) at inoculation site**
 - Painless
 - May go unnoticed
 - Often associated with regional or bilateral lymphadenopathy
 - Occur 10 – 90 days after infection
 - Highly infectious
 - Resolves in 1-6 weeks



Syphilis – Primary

- Primary Syphilis
 - Local
 - One or more ulcers (chancres) at inoculation site
 - **Painless**
 - **May go unnoticed**
 - **Often associated with regional or bilateral lymphadenopathy**
 - Occur 10 – 90 days after infection
 - Highly infectious
 - Resolves in 1-6 weeks

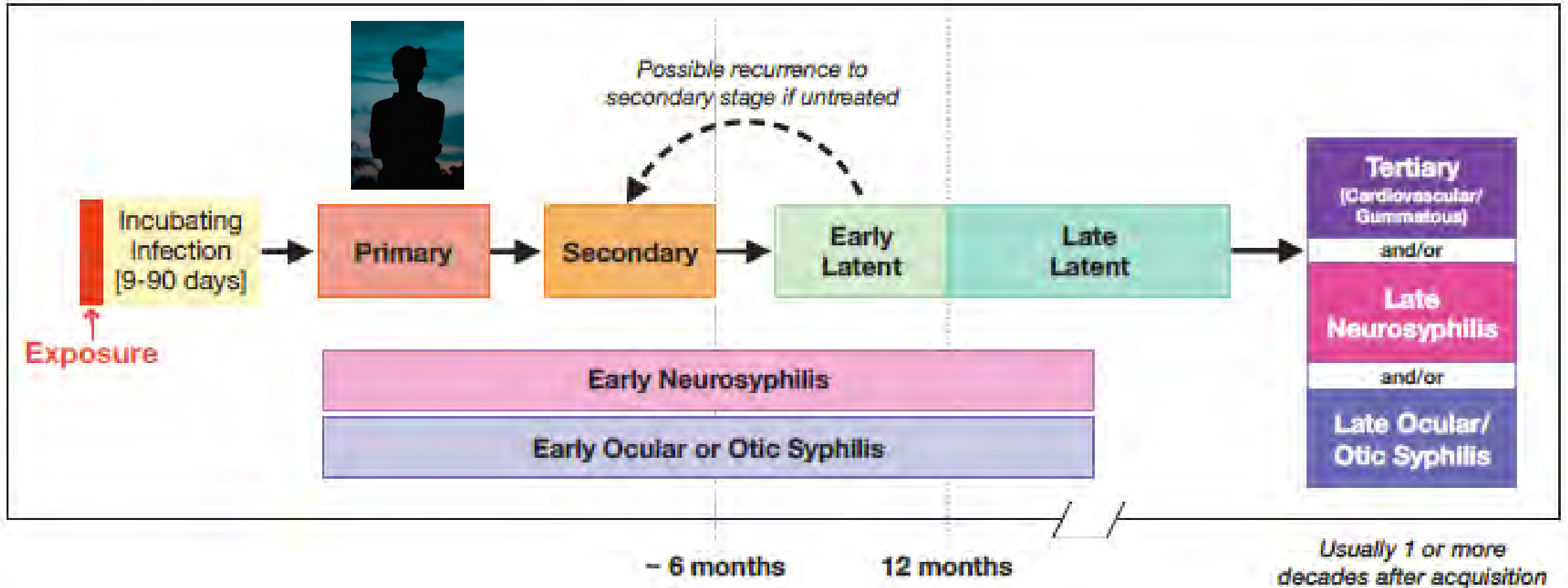


Syphilis – Primary

- Primary Syphilis
 - Local
 - One or more ulcers (chancres) at inoculation site
 - Painless
 - May go unnoticed
 - Often associated with regional or bilateral lymphadenopathy
 - **Occur 10 – 90 days after infection**
 - **Highly infectious**
 - **Usually resolves 6 weeks**



Primary Syphilis



2021 STI Guideline Updates to Primary Syphilis

- Classic Presentation
 - Single painless ulcer or chancre at the site of infection
- **Atypical presentations**
 - Multiple, atypical, or painful lesions at the site of infection

ORIGINAL ARTICLE

Painful and multiple anogenital lesions are common in men with *Treponema pallidum* PCR-positive primary syphilis without herpes simplex virus coinfection: a cross-sectional clinic-based study

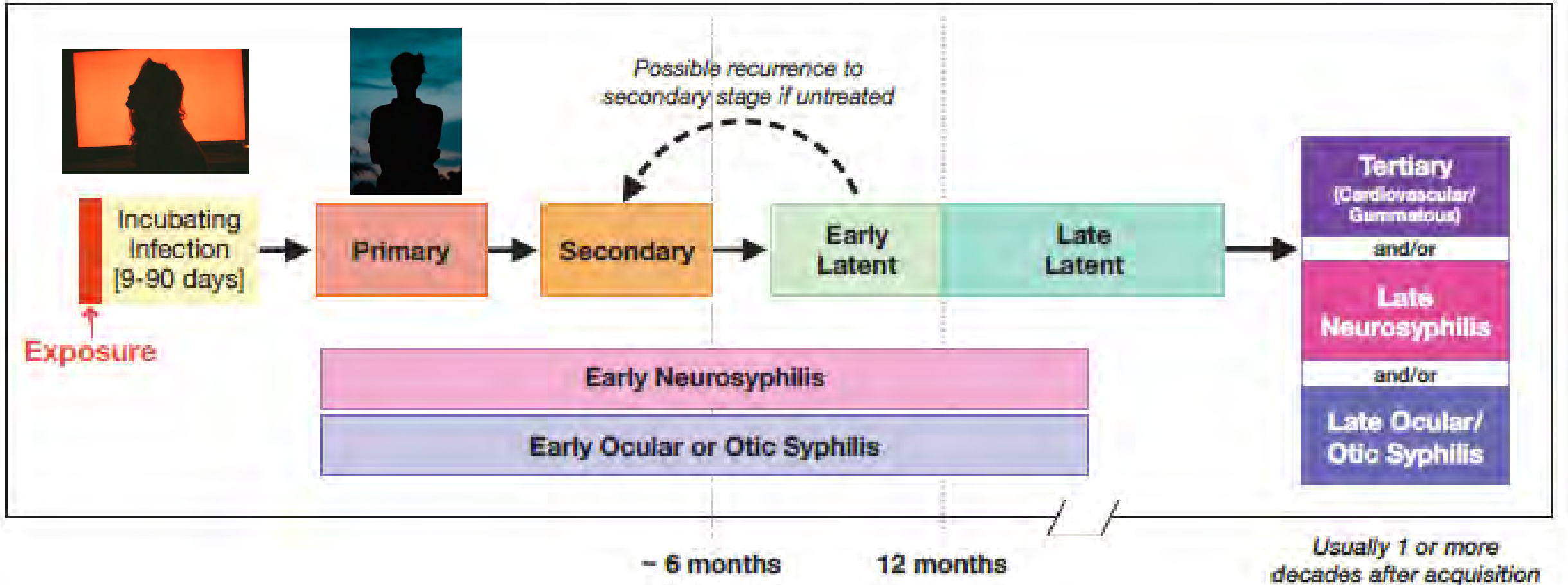
Janet M Towns,¹ David E Leslie,² Ian Denham,¹ Francesca Azzato,² Christopher K Fairley,^{1,3} Marcus Chen^{1,3}

Meet Janice



- 25-year-old female
- Presents for “routine STI testing”
- In a new (last 3 weeks) relationship with a bisexual male who was recently diagnosed with syphilis (Joseph)
- She reports no lesions, no rash, and her exam is benign

Syphilis – Incubation



Meet Jordan

- 30-year-old man who has sex with men who started PrEP 6 months ago
- Presents to clinic today for a routine PrEP visit and notes a recent history of diffuse skin rash that has now faded without any persistent symptom
- 6 weeks ago he presented to an urgent care when the rash appeared, and was sent home with a topical steroid cream



Jordan's Urgent Care Visit

- Diffuse, non-pruritic, non-painful, rash
- Erythematous macules and patches on his chest, axilla, abdomen, and bilateral upper and lower extremities



Jordan's Urgent Care Visit



Secondary Syphilis

- A stage of infection caused by *T. pallidum* characterized by localized or diffuse mucocutaneous lesions (e.g., rash – such as non-pruritic macular, maculopapular, papular, or pustular lesions), often with generalized lymphadenopathy
- Other signs can include mucous patches, condyloma lata, and alopecia
- **The primary ulcerative lesion may still be present**



Secondary Syphilis

- Secondary Syphilis
 - **Bacterial Dissemination**
 - **Dermatologic manifestations**
 - Systemic symptoms
 - Low-grade fever
 - Fatigue
 - Painless generalized adenopathy
 - Usually, 4-8 weeks after infection
 - Resolves in 6 weeks
 - Highly infectious



Secondary Syphilis

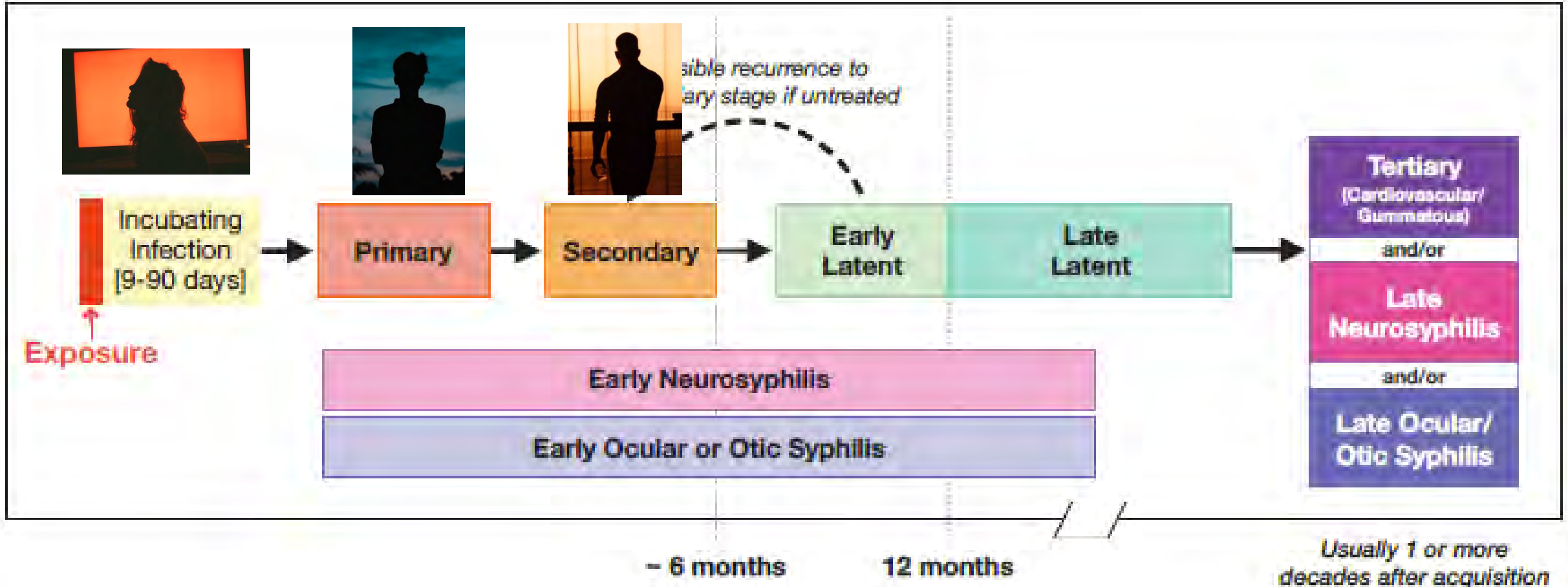
- Secondary Syphilis
 - Bacterial Dissemination
 - Dermatologic manifestations
 - **Systemic symptoms**
 - **Painless generalized adenopathy**
 - **Low-grade fever**
 - **Fatigue**
 - Usually, 4-8 weeks after infection
 - Resolves in 6 weeks
 - Highly infectious



Syphilis - Secondary

Organ System	Clinical Findings
Skin and Mucous Membranes	<ul style="list-style-type: none"> Rash or other skin lesions with varied appearance frequently on palms/soles <ul style="list-style-type: none"> Macular/papular/maculopapular Annular Psoriasiform Necrotic (rare) Condyloma lata: moist, gray-white, wart-like growths appearing in warm moist areas such as the perineum and the anus Patchy alopecia, often with a moth-eaten appearance Mucous patches: flat, silver-gray discrete macules, plaques or erosions involving the mouth, tongue, or ano-genital mucosa Split- or fissured-papules at the angles of the mouth and nasolabial folds (rare)
Systemic	<ul style="list-style-type: none"> Lymphadenopathy Systemic symptoms including: malaise, fever, and other nonspecific constitutional symptoms
Gastrointestinal	<ul style="list-style-type: none"> Gastric syphilis Hepatitis (usually subclinical)
Renal	<ul style="list-style-type: none"> Glomerulonephritis Nephrotic syndrome
Musculoskeletal	<ul style="list-style-type: none"> Arthritis Periostitis

Syphilis – Secondary/Early Latent



Today's Visit with Jordan

- A few days ago Jordan felt like he was having a hard time hearing the TV
- Went to ED and was seen by ENT
 - “Asymmetric hearing loss, please get MRI”
 - MRI unremarkable
 - Told to follow-up outpatient



Today's Visit with Jordan

- At today's visit, Jordan notes that he's also having a hard time reading his homework
- A thorough neurologic exam reveals decreased visual and auditory acuity, but no other CN abnormalities
- You send him urgently to the ophthalmology clinic
- On the note from his fundoscopic exam:
 - “Panuveitis”



Clinical Descriptions of Ocular and Otic Manifestations

Ocular Syphilis

- Often presents as panuveitis
- Can involve any structure in the anterior and posterior segment of the eye including:
 - Conjunctivitis
 - Red eye/Pain
 - Anterior uveitis
 - Posterior interstitial keratitis
 - Optic neuropathy
 - Retinal vasculitis
- Can lead to **permanent** vision loss

Otosyphilis

- Typically presents with cochleo-vestibular symptoms including
 - Tinnitus
 - Vertigo
 - Sensorineural hearing loss
 - Unilateral/Bilateral
 - Have a sudden onset
 - Progress rapidly
- Can result in **permanent** hearing loss

Other Neurosyphilis Manifestations

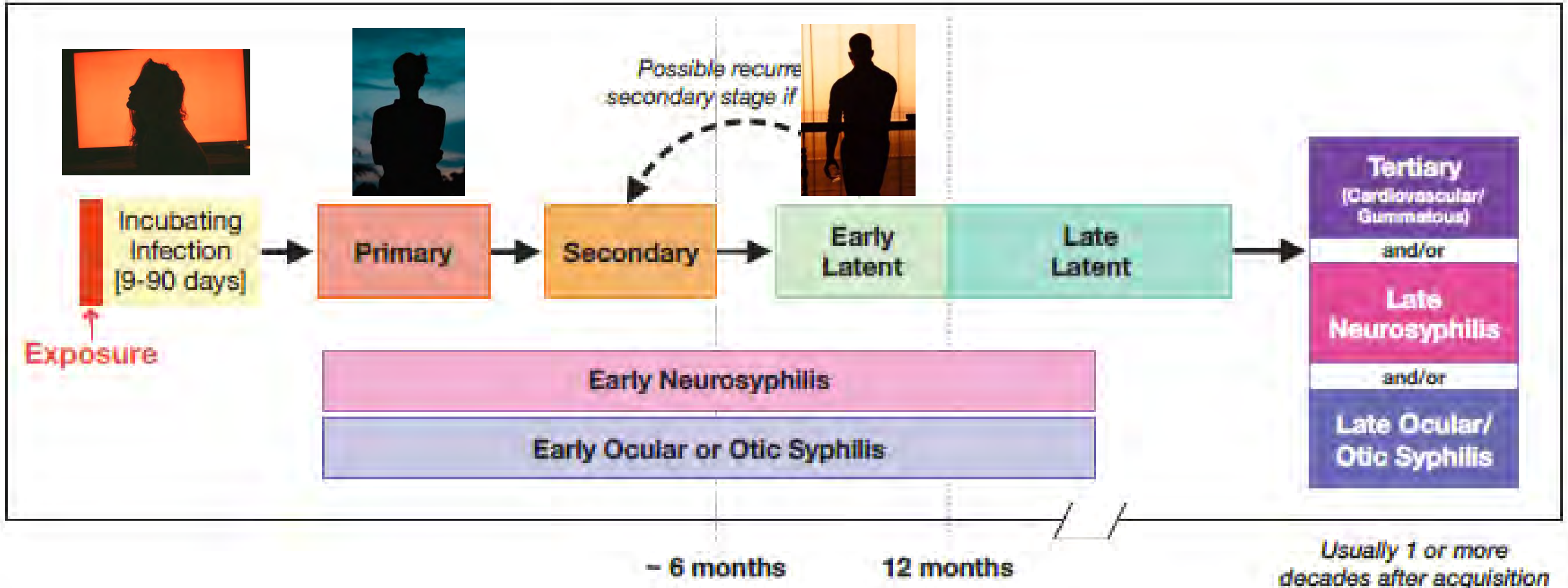
NEUROSYPHILIS SYNDROME	ONSET	POSSIBLE SYMPTOMS & CLINICAL FINDINGS (Exam findings are listed in bold)	
Asymptomatic Neurosyphilis	Soon after infected	None	
Acute Syphilitic Meningitis	Within 1st year <i>Can be seen during primary or secondary syphilis</i>	<ul style="list-style-type: none"> • Meningismus (headache, nuchal rigidity, photophobia) • Nausea, vomiting • Focal neurologic symptoms (vision changes, tinnitus, hearing loss, facial weakness or other cranial nerve symptoms) • Seizures 	<ul style="list-style-type: none"> • Symptoms of increased intracranial pressure • Nuchal rigidity (+ Kernig/Brudzinski signs) • Deafness (progressive or sudden) • Cranial nerve deficits (3rd, 6th, 7th, 8th CN) • Hemiplegia/Aphasia
Meningo-vascular Neurosyphilis (Rare spinal cord involvement)	Months to years (average 7 years)	<u>Infarction-related focal neurologic symptoms</u> <ul style="list-style-type: none"> • Paresthesias • Seizures • Hemiparesis, Hemiplegia • Aphasia • Hemianopsia (decreased vision or blindness in left or right half of visual field) 	<u>Pre-infarction symptoms</u> <ul style="list-style-type: none"> • Headache • Dizziness/vertigo • Stuttering stroke-like symptoms (weakness, paresthesias) • Psychiatric manifestations (mood, personality, or behavioral changes; irritability) • Memory loss, slowed mentation & speech

Screening for Neuro, Ocular, and Otic Syphilis

Screening Questions for Neurosyphilis (Including Ocular and Ootosyphilis)

Questions	
<u>Symptoms of Ootosyphilis</u>	
1) Have you recently had new trouble hearing?	<input type="checkbox"/> Yes – refer to ENT <input type="checkbox"/> No
2) Do you have ringing in your ears?	<input type="checkbox"/> Yes – refer to ENT <input type="checkbox"/> No
<u>Symptoms of Ocular syphilis</u>	
3) Have you recently had a change in vision?	<input type="checkbox"/> Yes – refer to ophthalmology <input type="checkbox"/> No
4) Do you see flashing lights?	<input type="checkbox"/> Yes – refer to ophthalmology <input type="checkbox"/> No
5) Do you see spots that move or float by in your vision?	<input type="checkbox"/> Yes – refer to ophthalmology <input type="checkbox"/> No
6) Have you had any blurring of your vision?	<input type="checkbox"/> Yes – refer to ophthalmology <input type="checkbox"/> No
<u>Symptoms of neurosyphilis</u>	
7) Are you having headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8) Have you recently been confused?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9) Has your memory recently gotten worse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10) Do you have trouble concentrating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11) Do you feel that your personality has recently changed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12) Are you having a new problem walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13) Do you have weakness or numbness in your legs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Syphilis – Secondary/Early Latent



Meet Jackie

- 29 year old female presents for a follow up visit
- She noted during a recent family planning visit that she was considering becoming pregnant
- Comprehensive STI testing was performed at that time at the discretion of the treating clinician, and included syphilis testing
- She has been referred to you for a positive result
- A pregnancy test from that visit was negative
- Prior syphilis testing two years ago was negative
- She notes no symptoms today, and has a normal exam



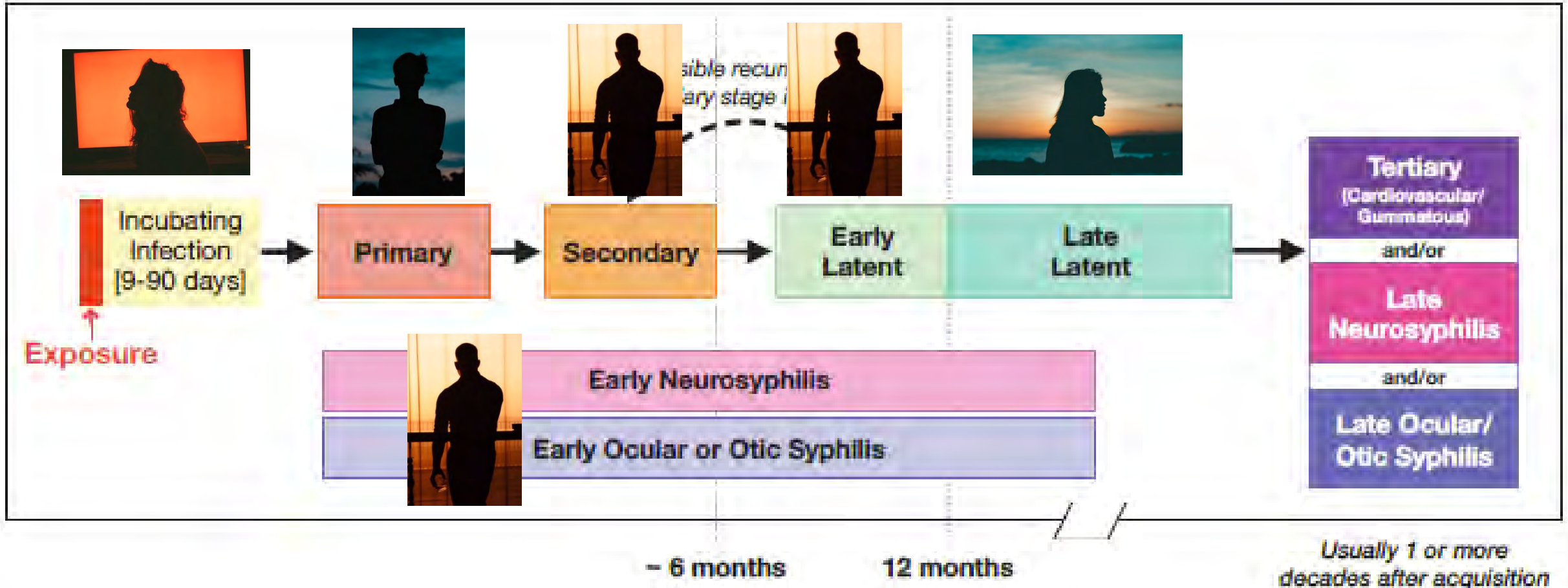
Syphilis – Latent

Latent Phase	Definition
Syphilis, early non-primary non-secondary	Duration of infection \leq 1 year
Syphilis, unknown duration or late	Duration of infection $>$ 1 year Unknown duration of infection

*****Latent syphilis requires no exam findings of primary, secondary or tertiary syphilis**

- Early latent disease is differentiated due to the risk of relapsed or intermittent bacteremia
 - This can occur in up to 24% of patients
 - Manifests as symptoms of secondary syphilis including CNS disease
- Risk for infecting partners remains
- Risk of relapsed symptoms and infectiousness decreases after 1 year

Syphilis – Secondary/Early Latent



Testing



How Do We Test for Syphilis?

- Multiple options exist to test directly for the presence of treponemes in primary syphilis lesions
 - Dark-field microscopy
 - Direct fluorescent antibody testing
 - T palladium NAAT
 - No FDA-approved tests are commercially available
- Unfortunately, these are not available in most clinical settings

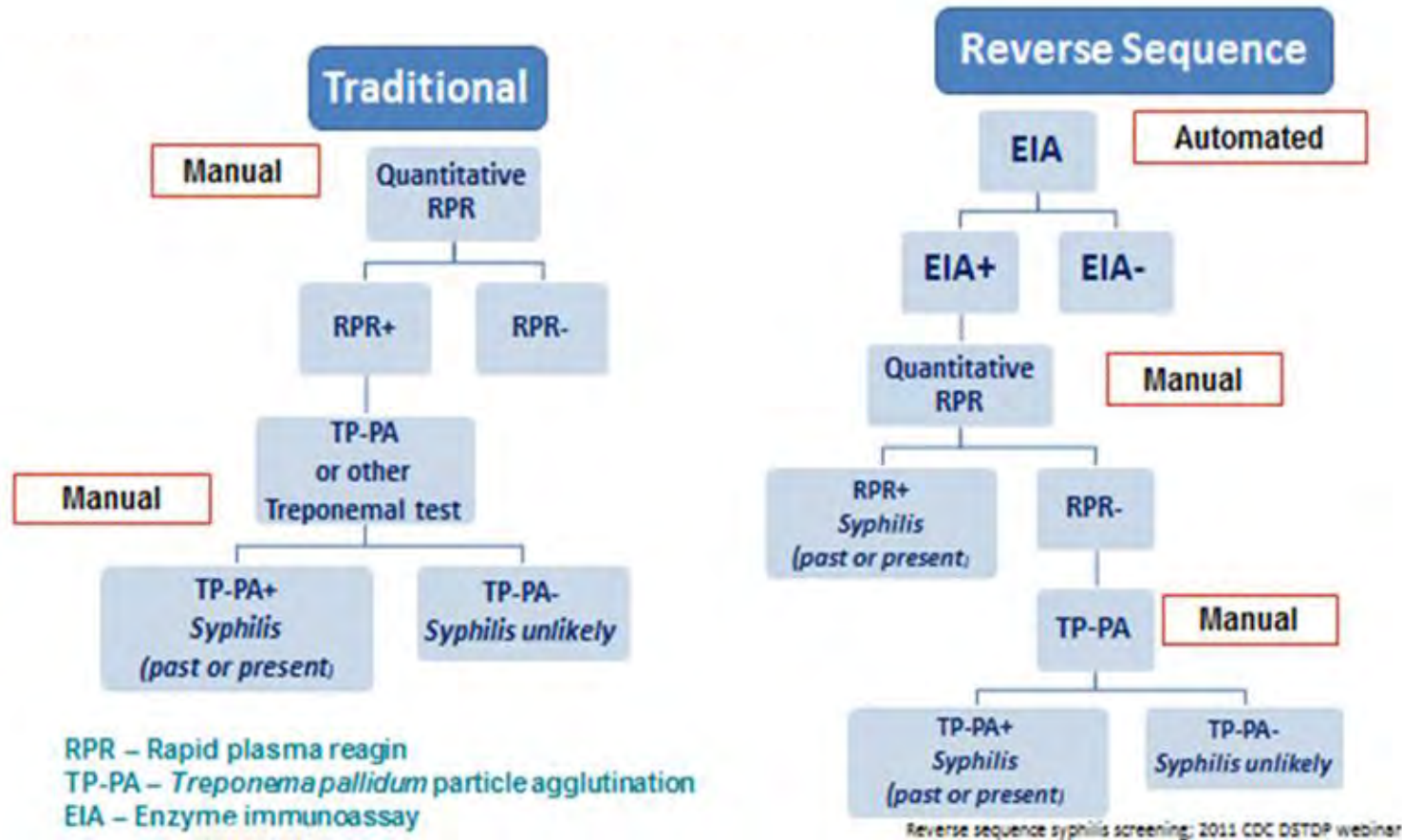
Serologic Testing

Non-treponemal (lipoidal antigen) tests	Treponemal tests
Test serum reactivity (presence of antibodies) to cardiolipin-cholesterol-lecithin	Test serum reactivity against T. pallidum-specific antigens
Antigen response is due both directly to bacteria and host tissue damage	More specific than non-treponemal tests
Up to 11% of positive tests in one series not due to T pallidum	Often remain positive for life
Degree of reactivity changes over disease course/after treatment	Generally automated
Generally manual	

Serologic Testing

Non-treponemal (lipoidal antigen) tests	Treponemal tests
Rapid plasma reagin (RPR)	Enzyme Immunoassay (EIA)
Venereal disease research laboratory (VDRL)	Fluorescent treponemal antibody (FTA-ABS)
	Treponema pallidum particle agglutination (TP-PA)
	Chemiluminescence assay (CIA)

Serologic Testing

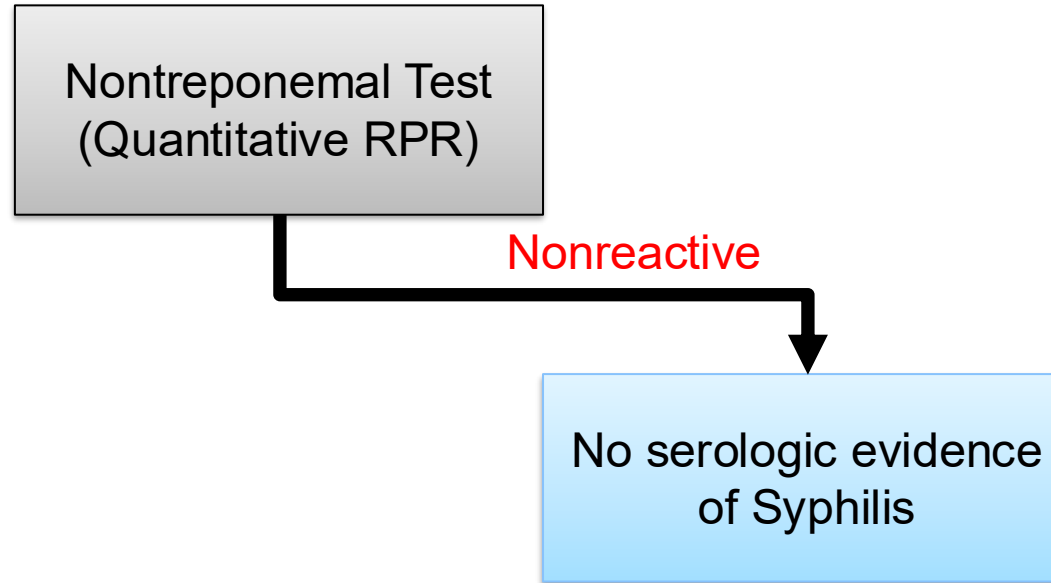


• Thanks to Hilary Reno and Joseph Cherabie from the St. Louis PTC for this slide

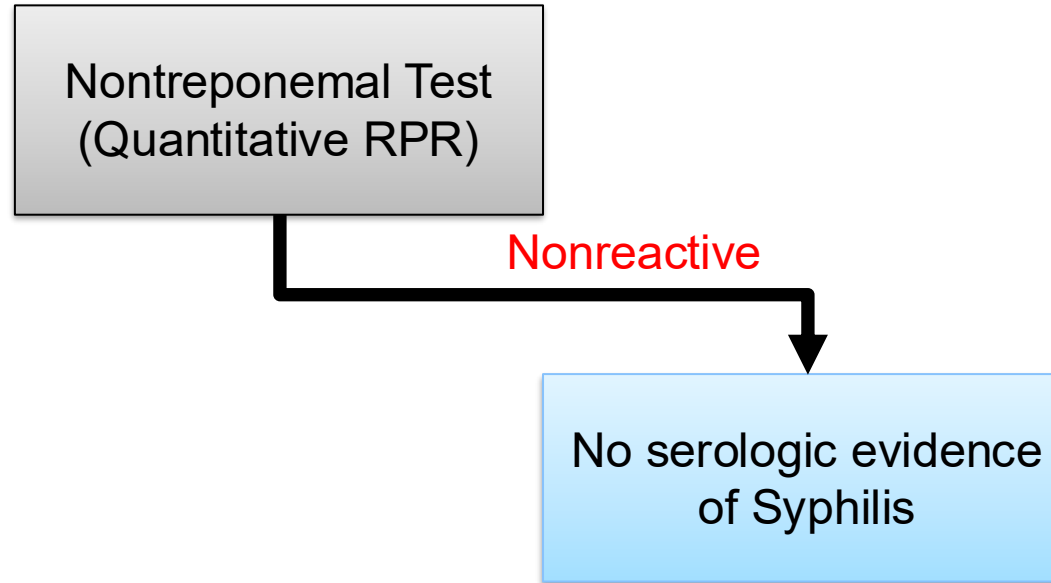
Syphilis – Traditional Algorithm

Nontreponemal Test
(Quantitative RPR)

Syphilis – Traditional Algorithm



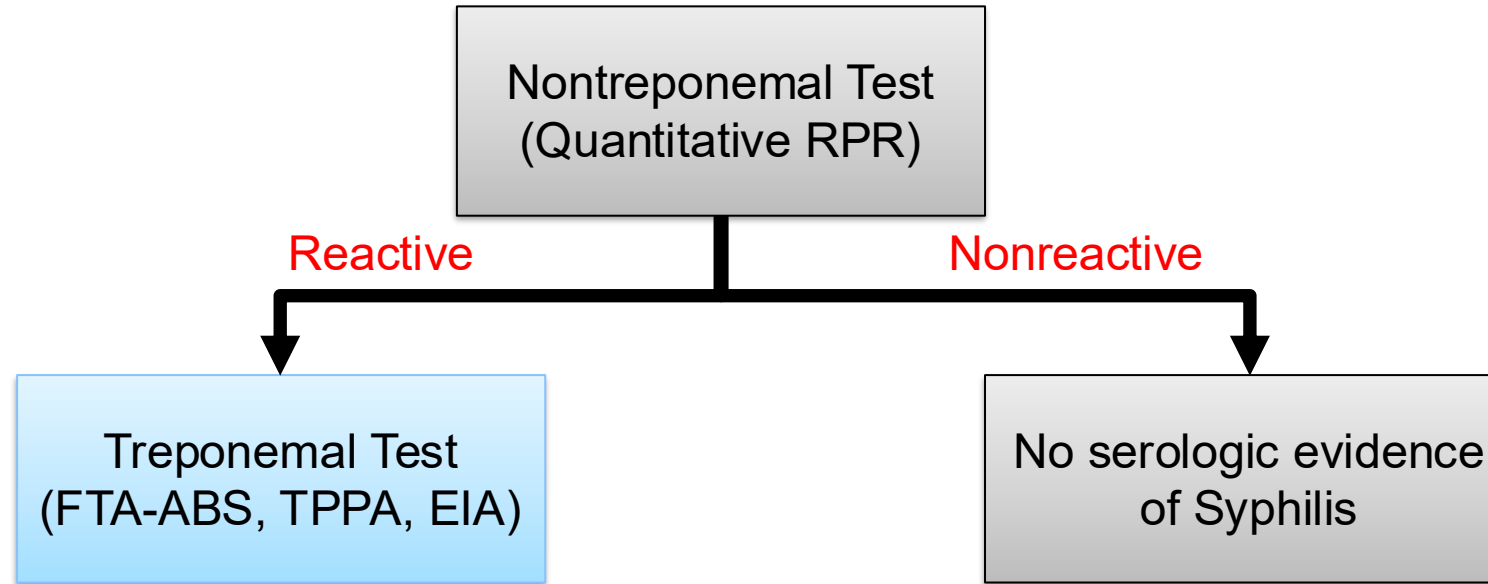
Syphilis – Traditional Algorithm



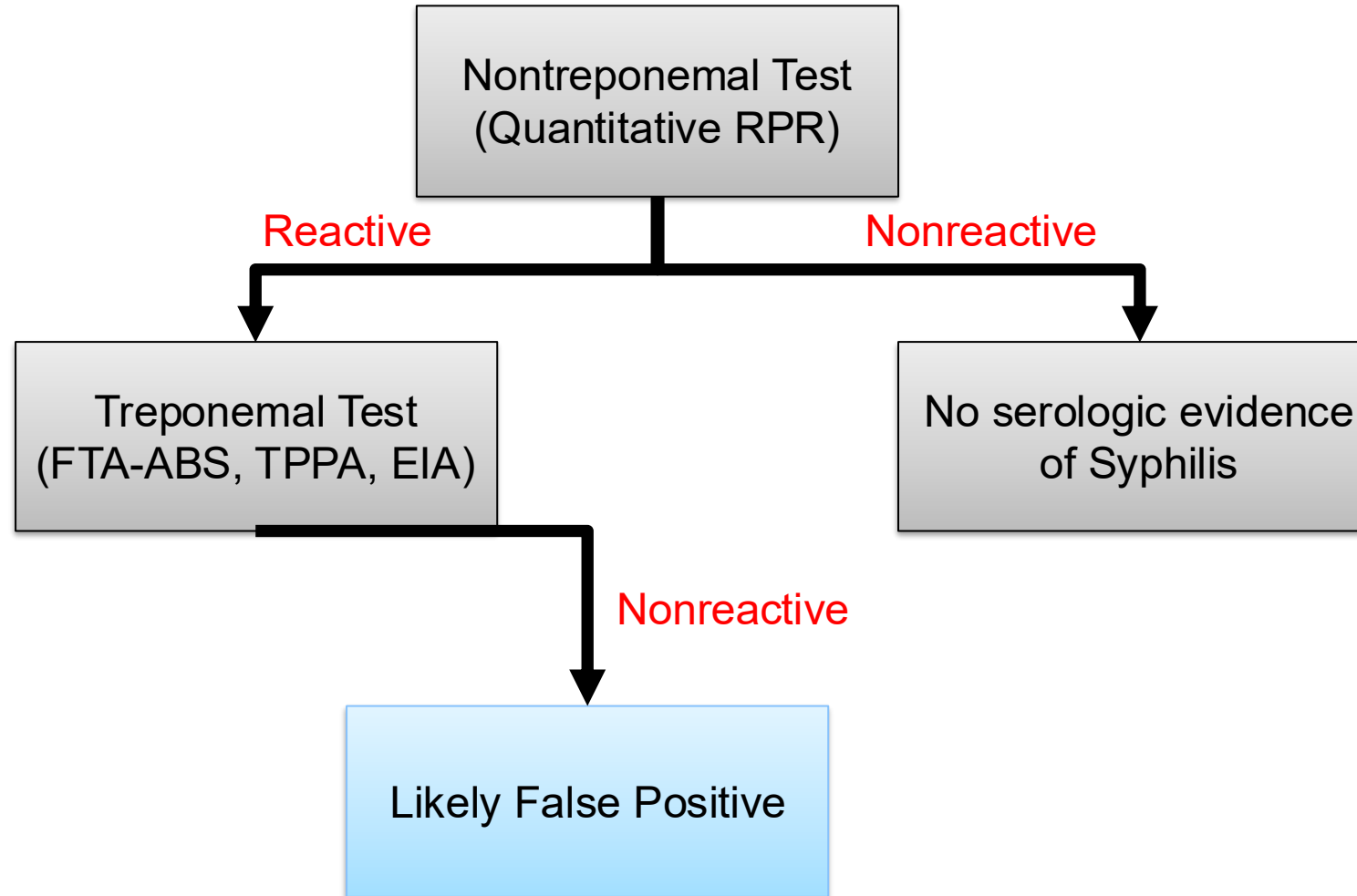
Limitations:

- Incubation period
- Early primary infection

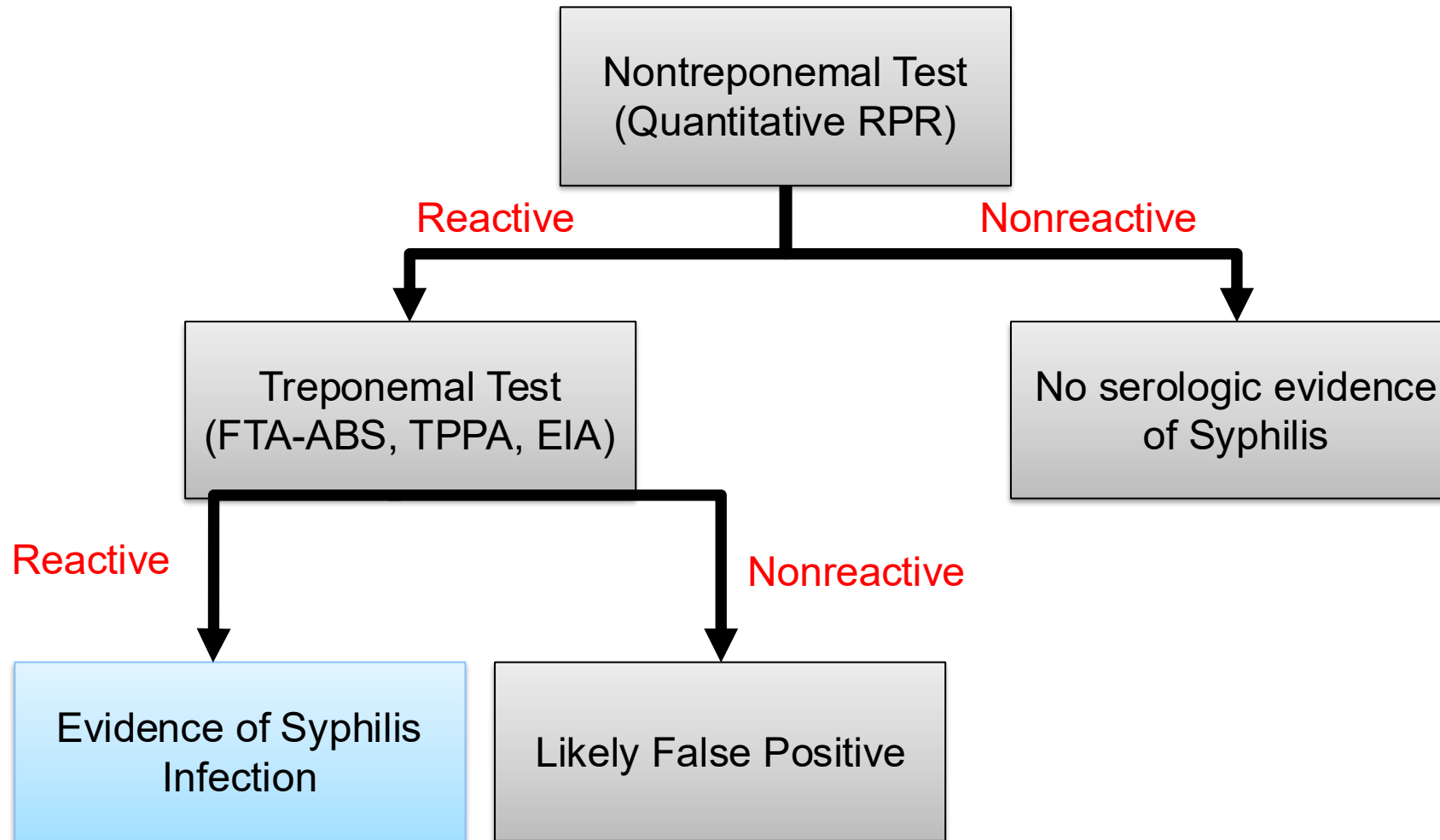
Syphilis – Traditional Algorithm



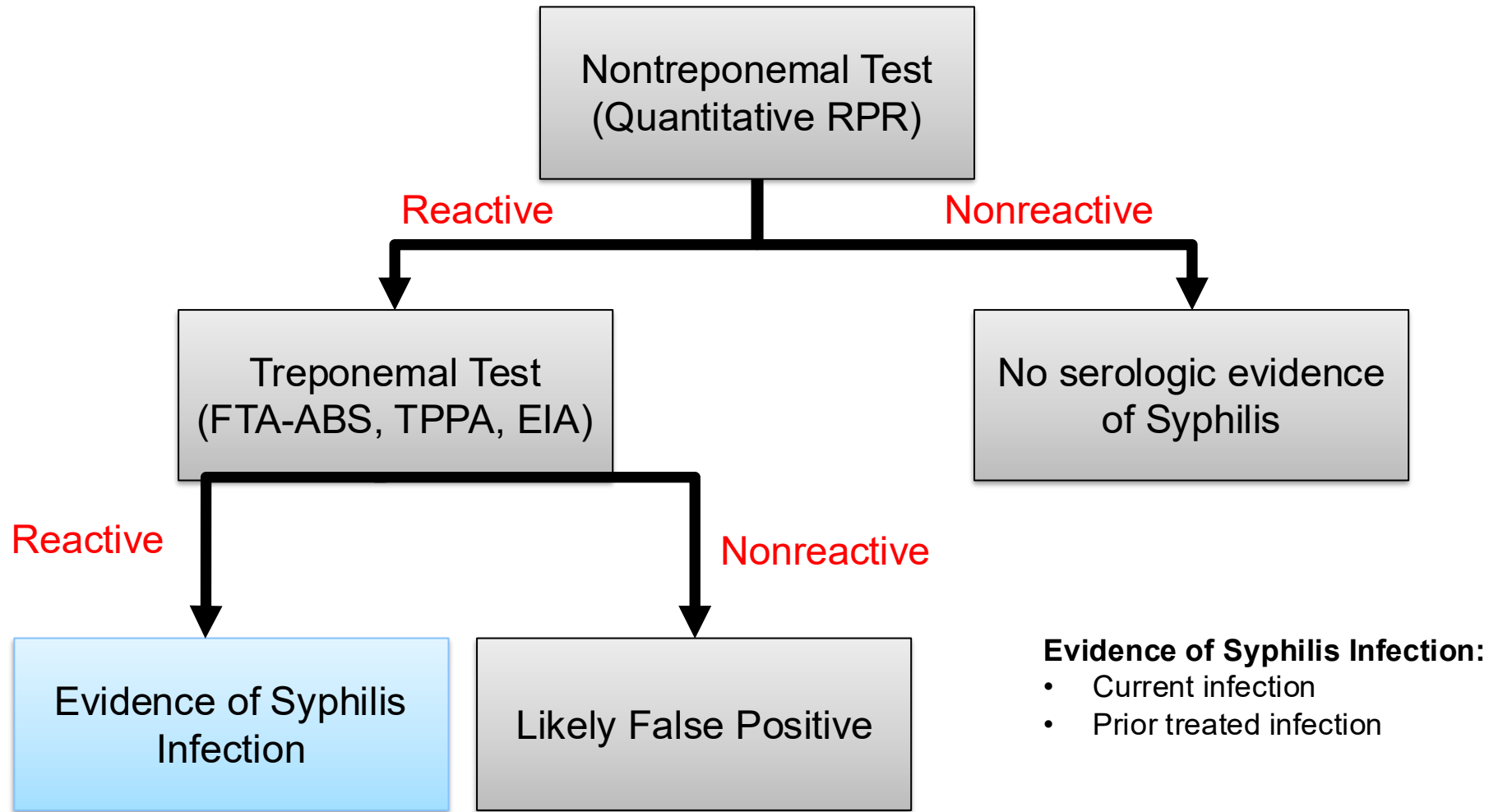
Syphilis – Traditional Algorithm



Syphilis – Traditional Algorithm



Syphilis – Traditional Algorithm

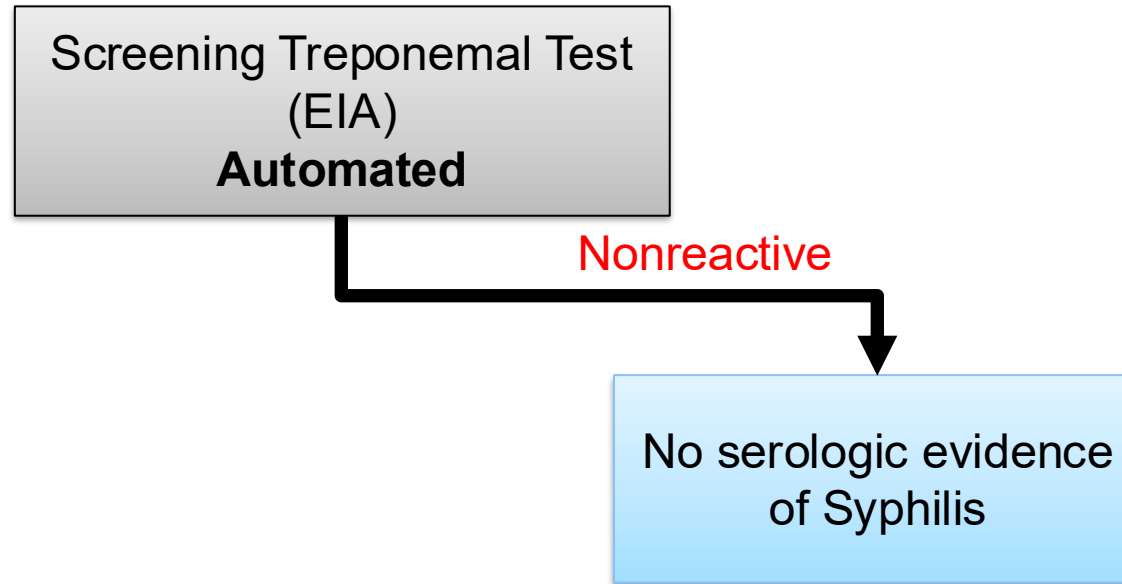


Syphilis – Reverse Algorithm

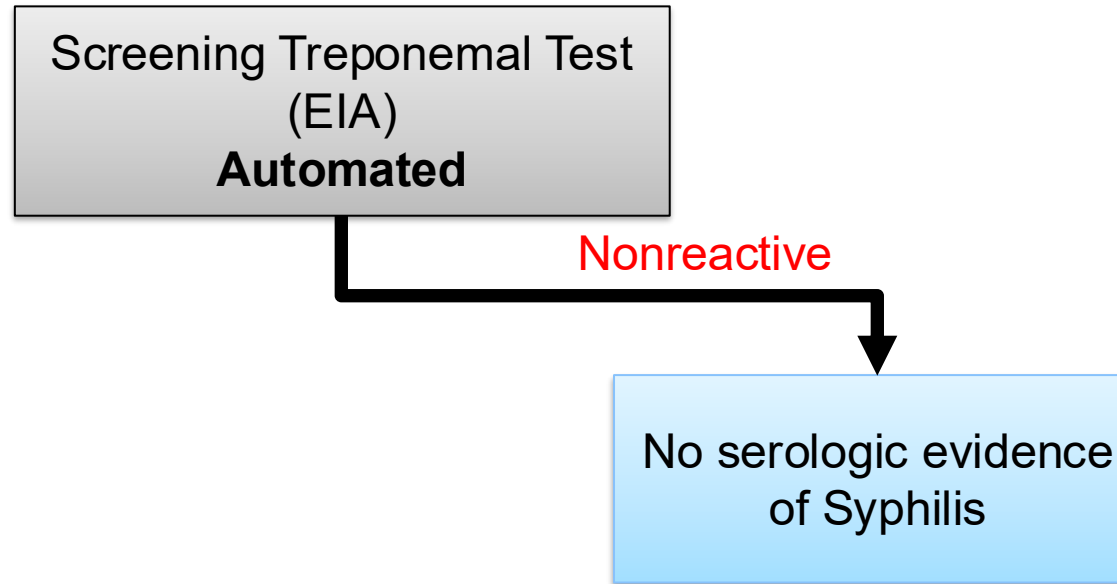
Screening Treponemal Test
(EIA)
Automated

- New York City Department of Health and Mental Hygiene, and the New York City STD Prevention Training Center. The Diagnosis and Management of Syphilis: An Update and Review. March 2019. A PDF version is available at <http://www.publichealth.columbia.edu/file/15568/download?token=exDNYpJ->

Syphilis – Reverse Algorithm



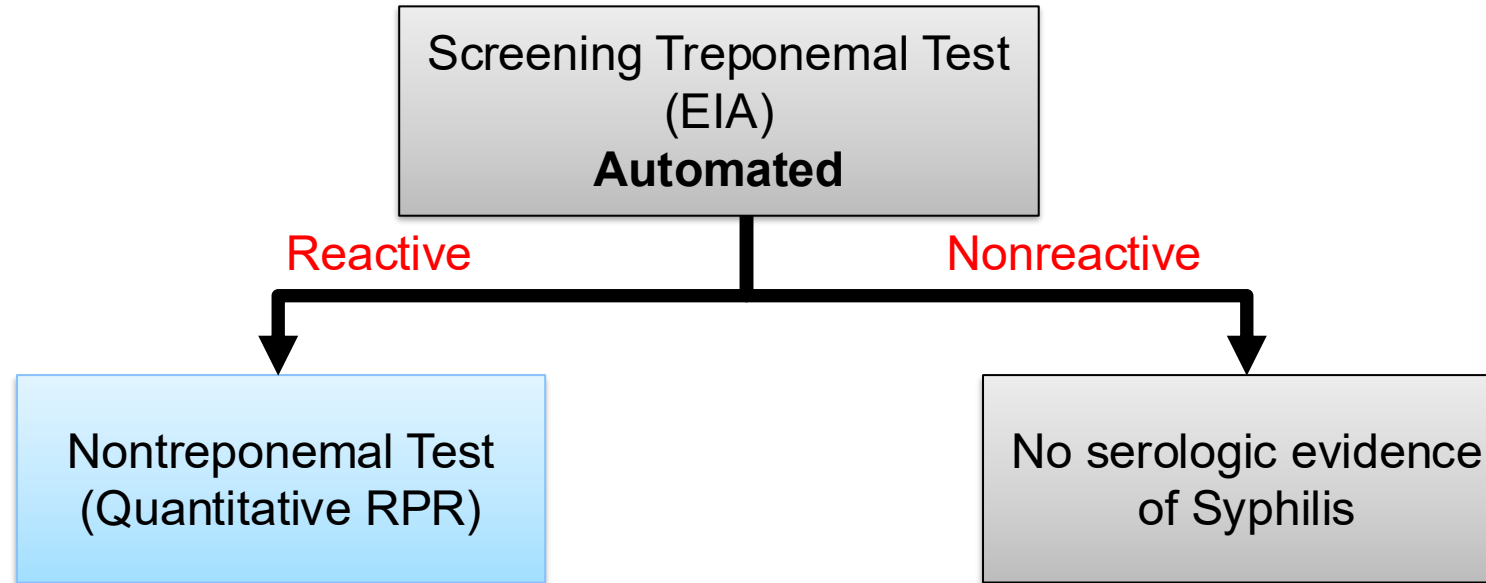
Syphilis – Reverse Algorithm



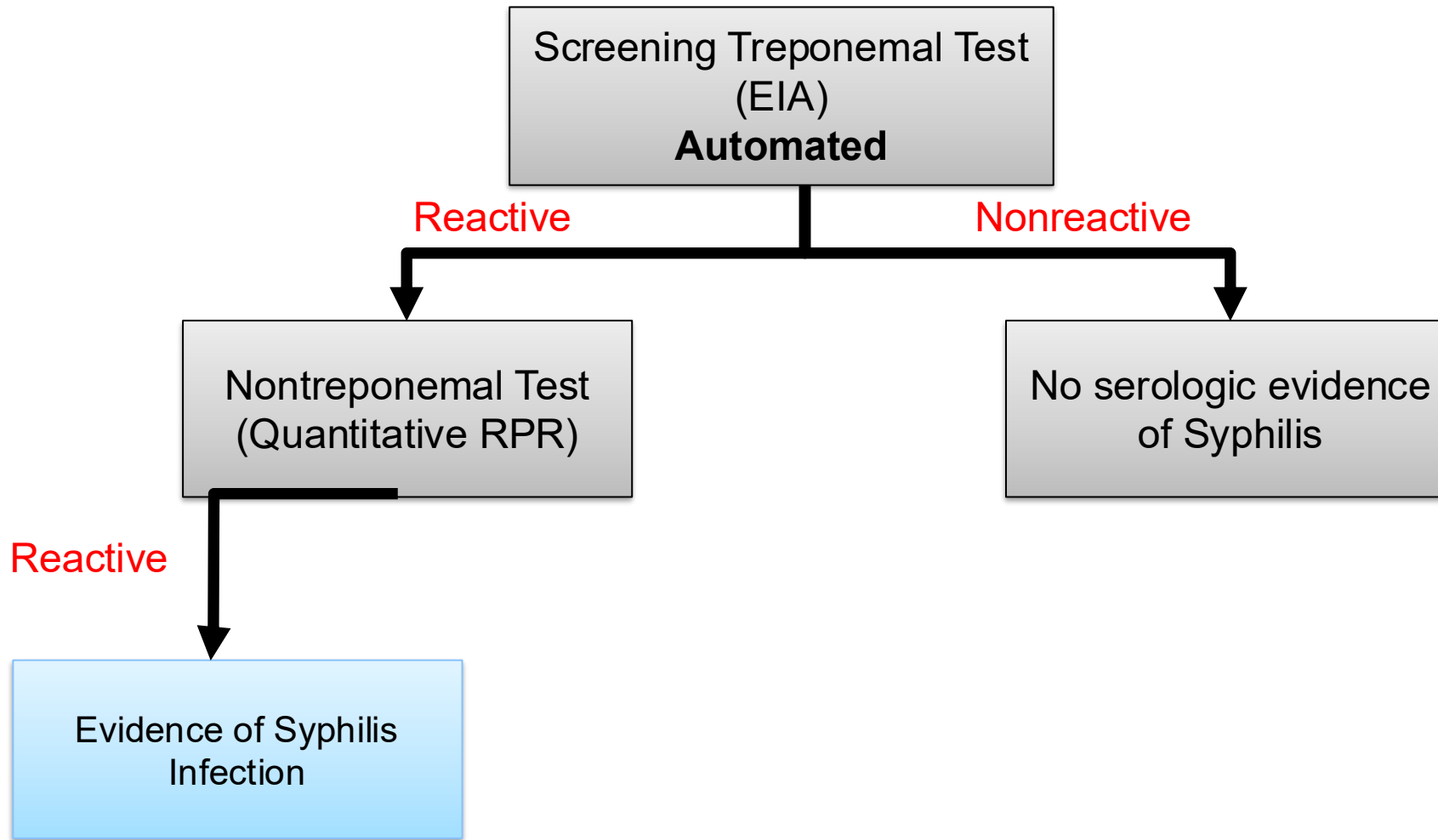
Limitations:

- Incubation period
- Early primary infection

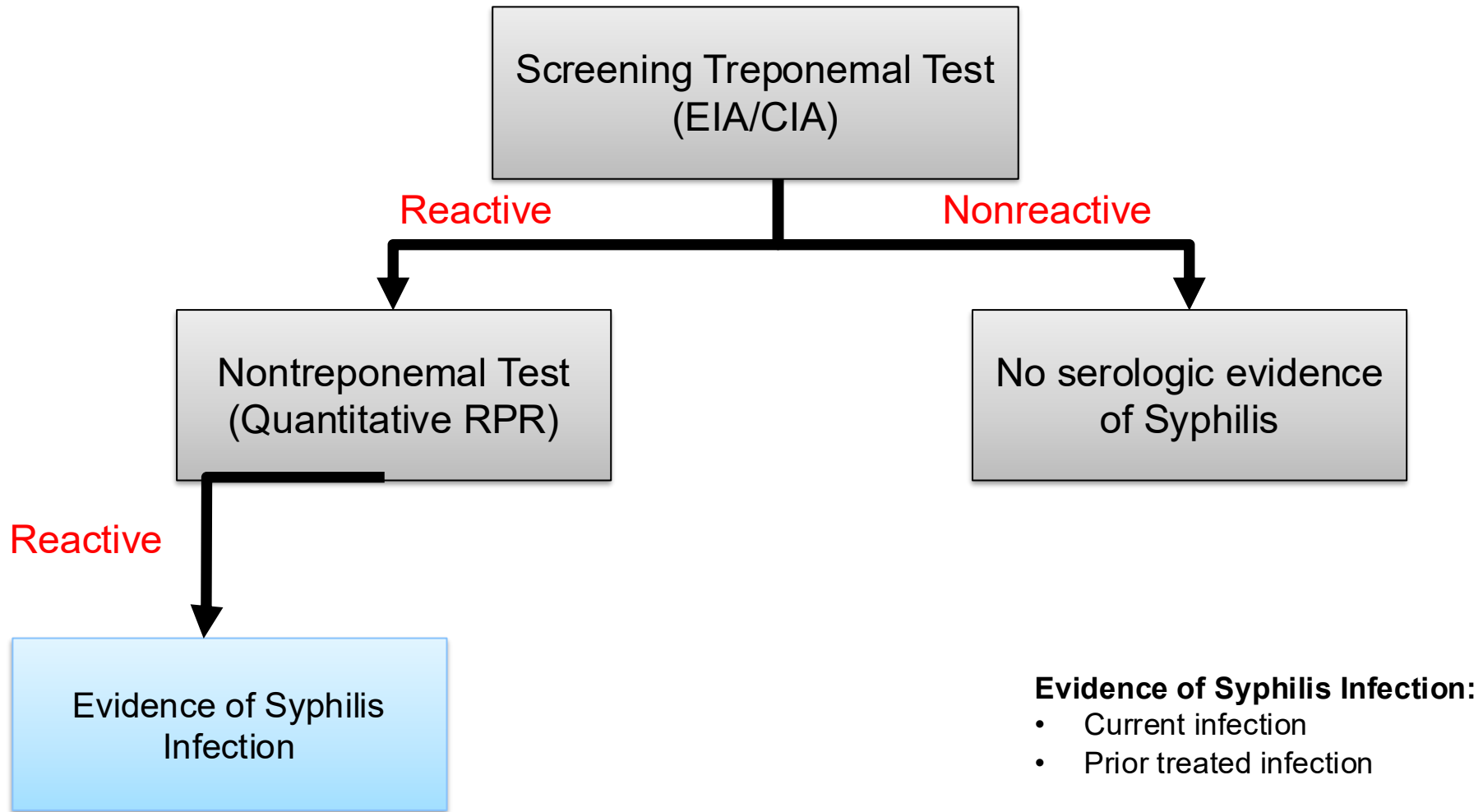
Syphilis – Reverse Algorithm



Syphilis – Reverse Algorithm



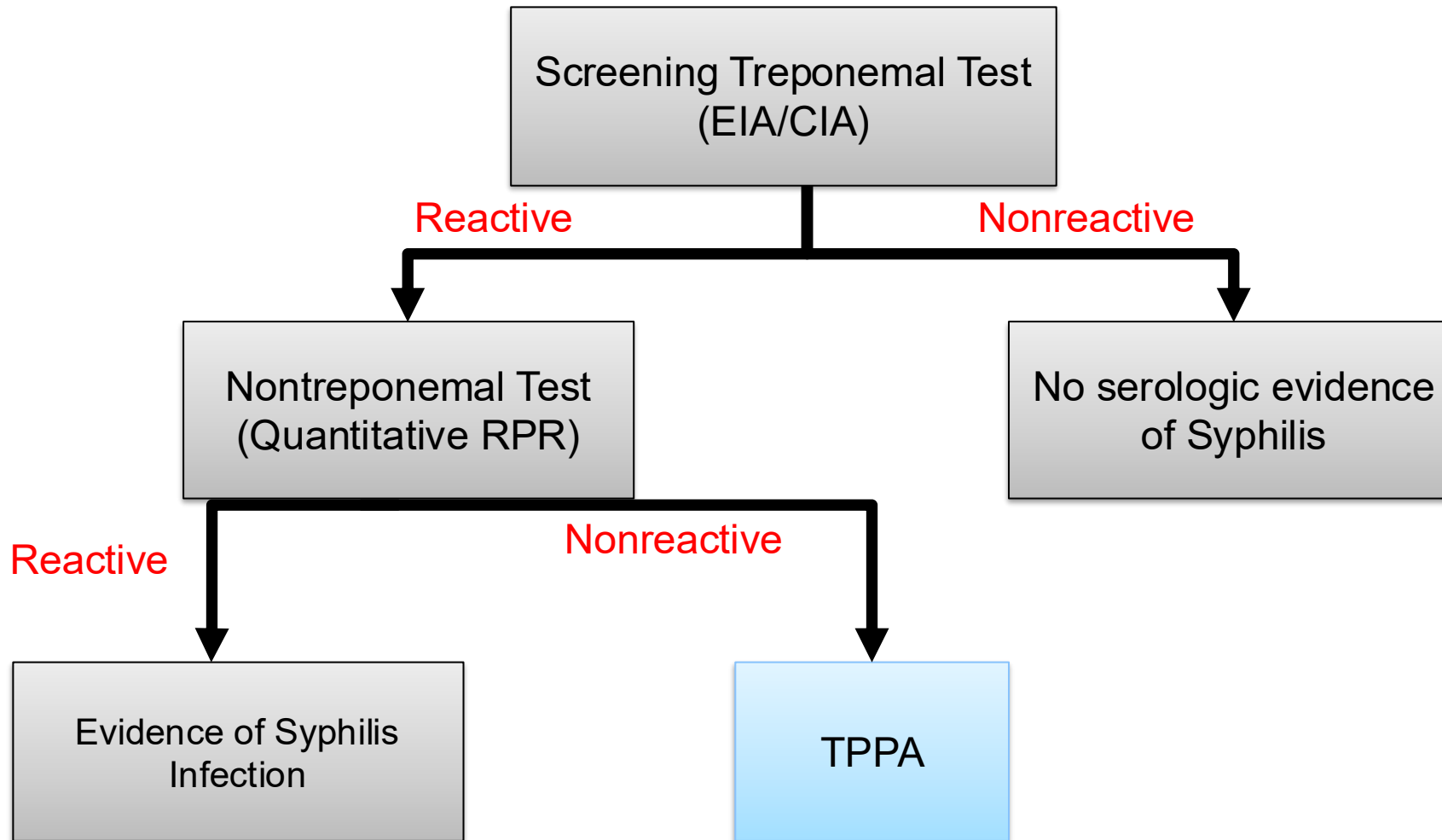
Syphilis – Reverse Algorithm



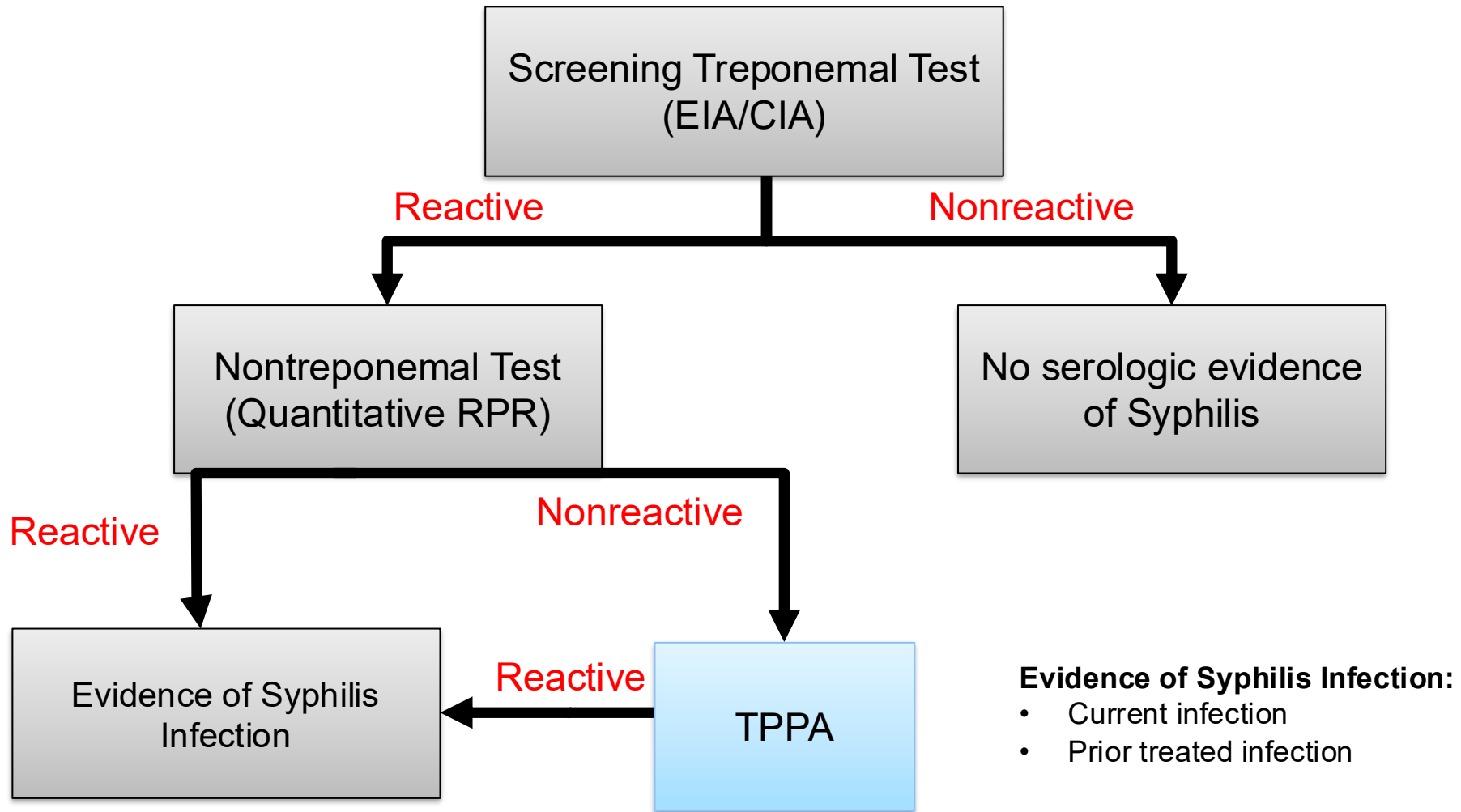
Evidence of Syphilis Infection:

- Current infection
- Prior treated infection

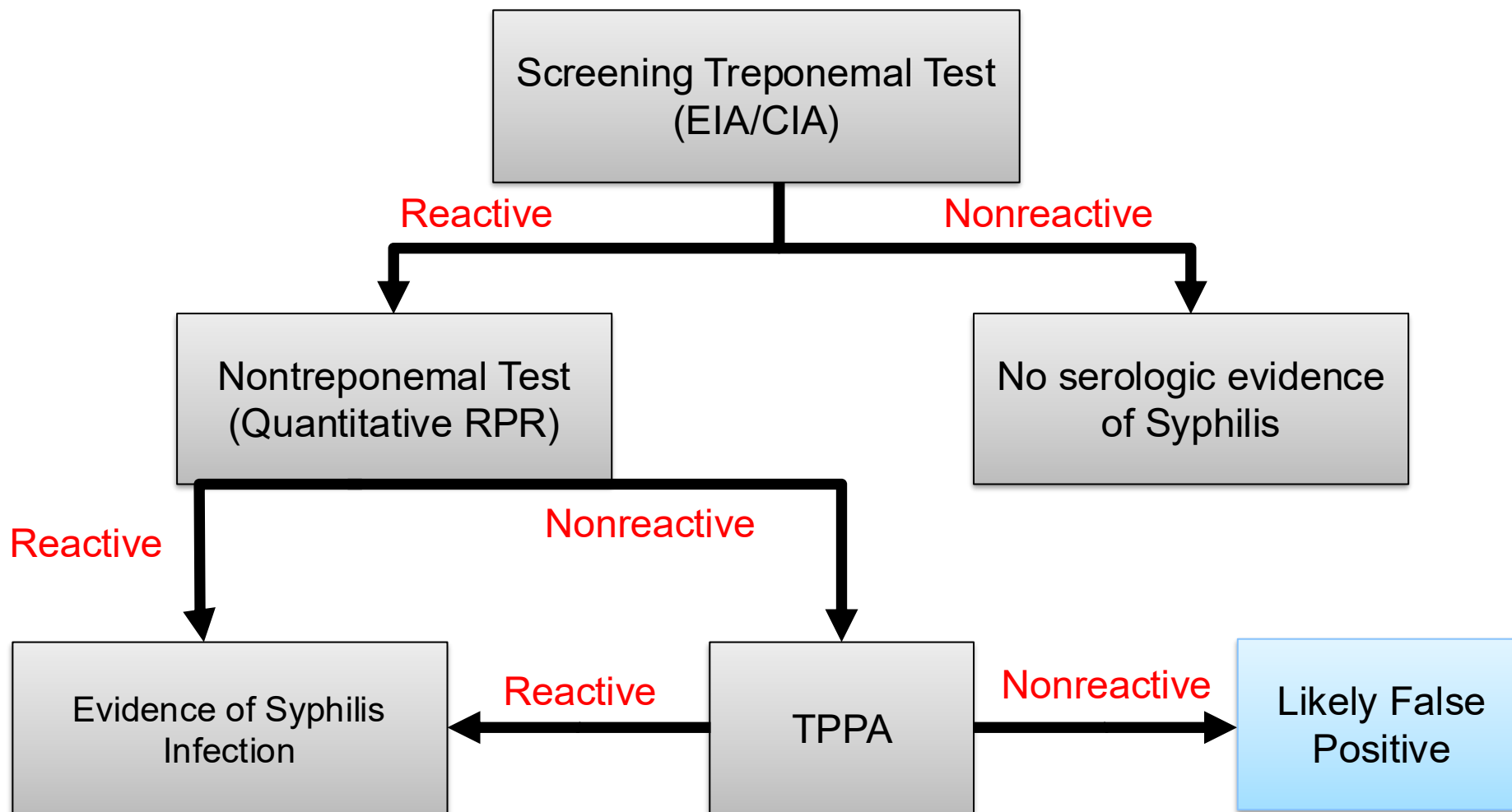
Syphilis – Reverse Algorithm



Syphilis – Reverse Algorithm



Syphilis – Reverse Algorithm



FAQ: What About People with Prior Syphilis?

- Treponemal tests typically remain positive for life following syphilis infection, and RPR sometimes remains reactive as well
- Comparing RPR titers to prior results is an important way to evaluate for re-infection
- Stay tuned for more!

FAQ: What About CNS Disease?

- Neurological disease previously always required diagnosis with CSF studies
- Hallmark CSF abnormalities include
 - Pleocytosis
 - >5 cells/mL in most patients
 - >20 cells/mL in people with HIV
 - Elevated protein
 - Limited sensitivity and specificity
 - Reactive CSF VDRL
 - Less than 80% sensitive, but specific



2021 Updates

Fewer Lumbar Punctures

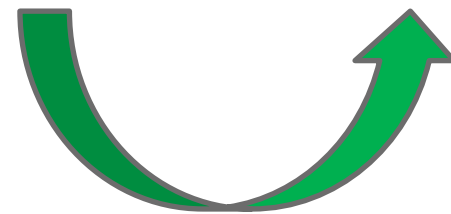
- Isolated ocular symptoms and no cranial nerve dysfunction
 - CSF exam is not necessary
- Otic syphilis
 - CSF exam is not necessary
- Neuro syphilis
 - No repeat CSF exam at 6 months with adequate RPR response (HIV - and HIV+/ART)



FAQ: When Do I Need to Report This?

- Processes for reporting new syphilis diagnoses vary by state/locality
- **Always check with your local Department of Health regarding reporting requirements and processes**

Treatment



stage

Finally, Treatment!

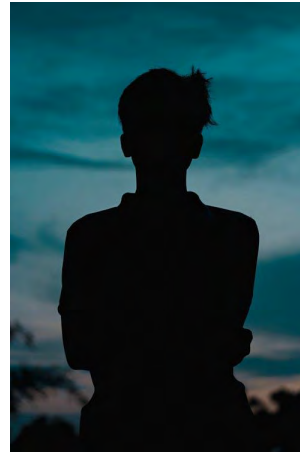
- Treatment continues to rely on penicillin, to which resistance has not been observed
- Long-acting benzathine penicillin-G sustains treponemocidal drug levels for 7-10 days
- Due to long generation times (33 hours), sustained drug levels are felt to be necessary for bacterial elimination
- Due to a recent shortage of this drug, doxycycline has been introduced as an alternative, supported primarily by retrospective studies
- On 1/16 the FDA announced that it would allow importation of Extencilline (an equivalent penicillin manufactured in Italy)

Syphilis Treatment – Early (Uncomplicated)

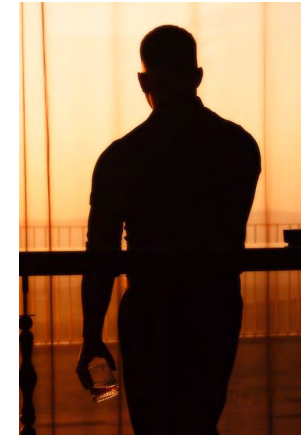
Stage	Treatment	Alternative
Incubation	Benzathine penicillin G 2.4 million units intramuscular injection once	Doxycycline 100mg twice daily for 14 days
Primary		
Secondary		
Syphilis, early non-primary non-secondary		



Incubation



Primary



Secondary/
early latent

Syphilis Treatment – CNS Disease



Neurosyphilis,
Ocular, or Otic Syphilis

Tertiary

Aqueous crystalline penicillin G
18–24 million units per day,
administered as 3–4 million units
intravenously every 4 hours, or by
continuous infusion, for 10–14
days

Procaine penicillin G 2.4
million units IM once daily
PLUS Probenecid 500mg 4
times daily for 10–14 days

Syphilis Treatment – Late Latent



Syphilis, unknown duration or late

Benzathine penicillin G 2.4 million units intramuscular injection 3 times at one week intervals

Doxycycline 100mg twice daily for 28 days

FAQ

- How many days between injections is acceptable for latent syphilis?
 - **General Population**
 - “If a person receives a delayed dose of penicillin in a course of weekly therapy for late latent syphilis or syphilis of unknown duration, the course of action that should be recommended is unclear”
 - Interval of 7–9 days **preferred**
 - An interval of 10–14 days between doses of benzathine penicillin for latent syphilis “**might**” be acceptable before restarting the sequence of injections
 - **Check with local health departments for their policies**
 - **Pregnant women**
 - Optimal Interval is 7 days
 - Missed doses >9 days between doses are **not acceptable**
 - Missed doses = repeat the full course of therapy

Follow Up and Treatment Failure

- Quantitative nontreponemal serologic tests should be repeated at least at:
 - 6 months
 - 12 months
 - 24 months (for latent disease)
- An inadequate serologic response after treatment is failure for titers to decrease by 4x:
 - 12 months after treatment for primary, secondary
 - 24 months after treatment for latent disease

Syphilis – Interpreting RPR Titers



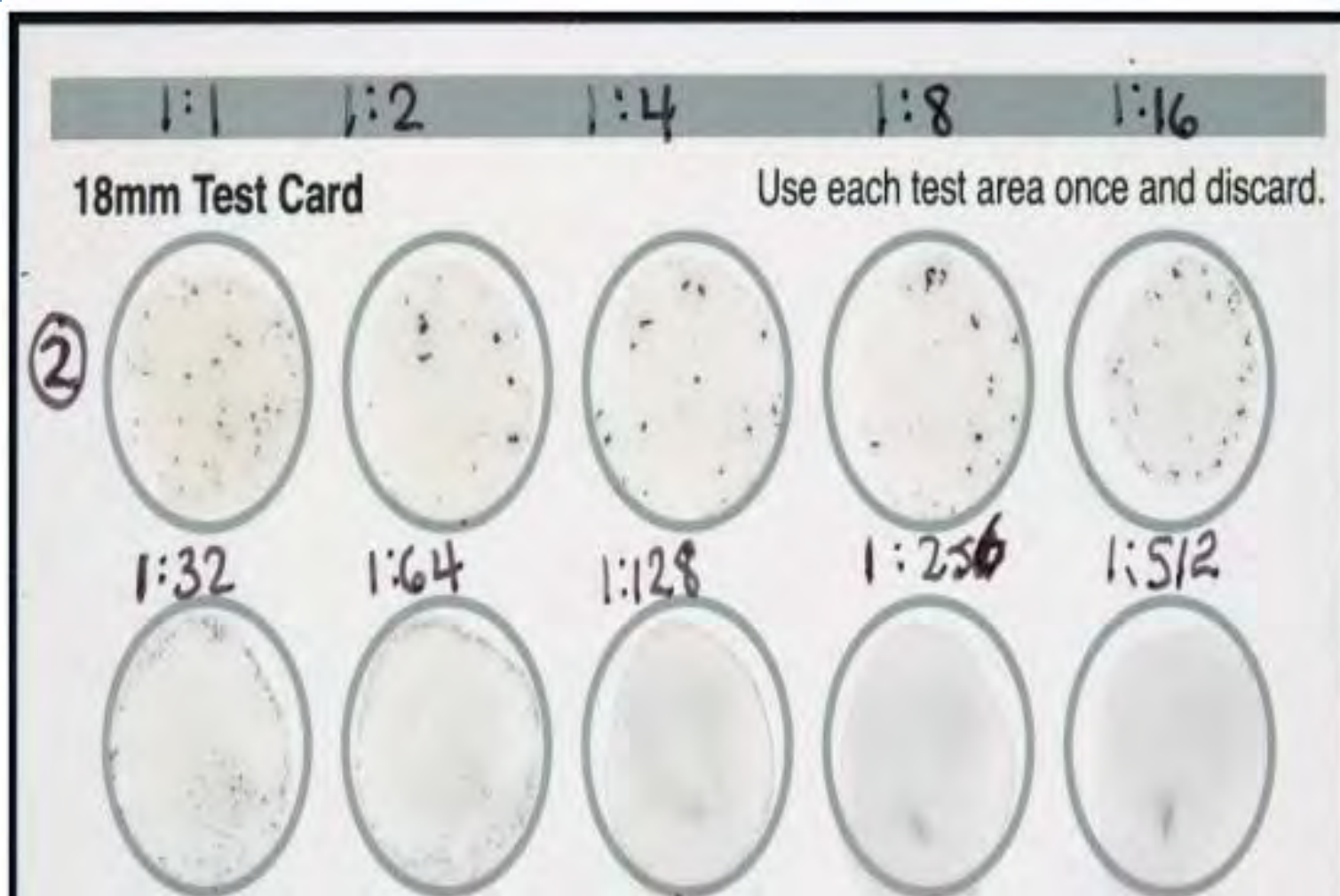
Just What is an RPR?

Rapid plasma reagin



- Antibodies in patient serum bind to antigen composed of cholesterol, non-specific cardiolipin, and lecithin
- Antibody-antigen complexes forms lattices around charcoal particles, which appears as agglutination (clumping)
- Value = highest ratio of antigen:serum that still results in agglutination (higher number = more antibodies)
- Antigen is present both in bacterium and in host tissue—response reflects both bacterial burden and tissue damage

How Do We Get an RPR Titer?



1:2048

1: 1024

1:512

1: 256

1:128

1: 64

1:32

1: 16

1:8

1: 4

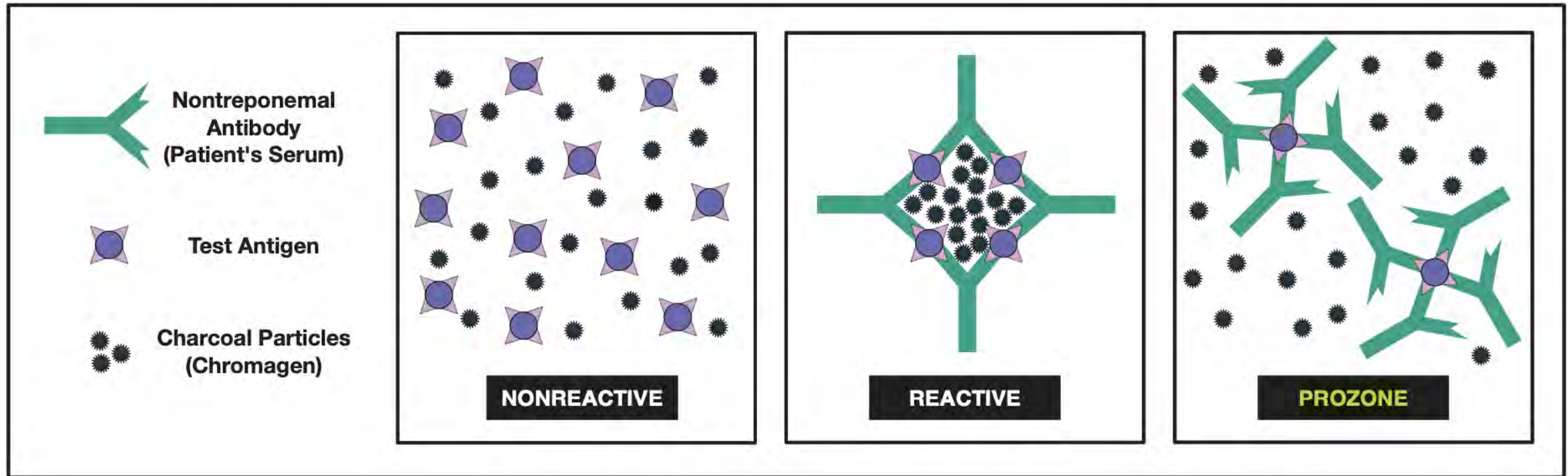
1:2

1: 1

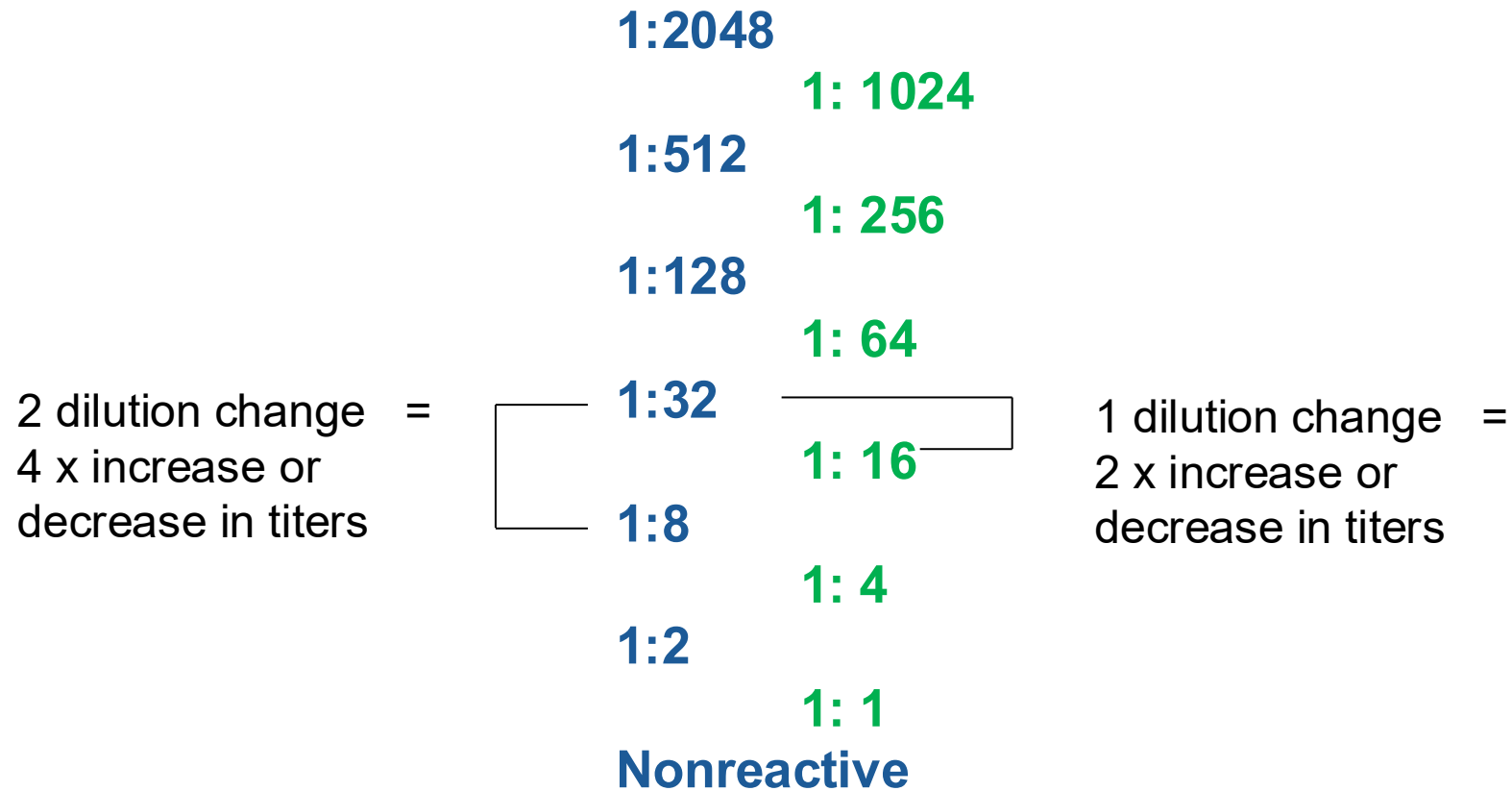
Nonreactive

What's Actually Happening in There?

Figure 7. The Mechanism Underlying Nontreponemal Syphilis Serologic Assays




Interpreting RPR Titers

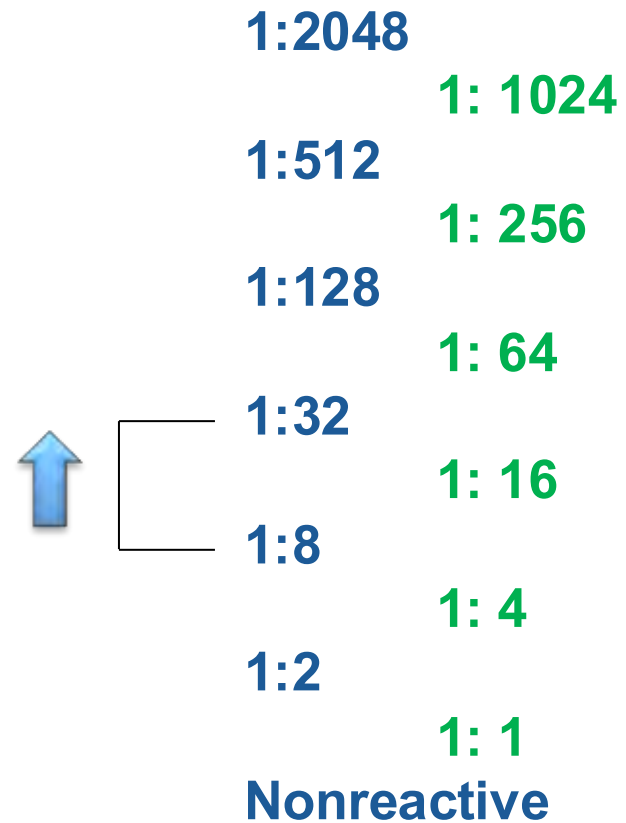


Syphilis – Interpreting RPR Titers

1:2048	1: 1024
1:512	1: 256
1:128	1: 64
1:32	1: 16
1:8	1: 4
1:2	1: 1
Nonreactive	



Syphilis – Interpreting RPR Titers



Follow Up and Treatment Failure

- Quantitative nontreponemal serologic tests should be repeated at least at:
 - 6 months
 - 12 months
 - 24 months (for latent disease)
- An inadequate serologic response after treatment is failure for titers to decrease by 4x:
 - 12 months after treatment for primary, secondary
 - 24 months after treatment for latent disease

FAQ: Which Partners to Notify?

- Transmission
 - “Microscopically abraded” **skin**
 - **Mucous membrane** lesions
- Skin and mucous membrane lesions occur during the first year after infection and can be easily missed

STAGE OF INFECTION	MAXIMUM PERIOD OF INFECTION * (Prior to symptom onset or first serologic evidence of infection/reinfection)	MANAGEMENT OF CONTACTS AT RISK FOR EXPOSURE
Incubating Infection	Persons being treated presumptively for incubating infection following a known exposure, who lack any exam or serologic evidence of syphilis, are not considered infectious—but will become infectious if left untreated. Therefore, contacts of persons treated for incubating infection are not at risk of exposure but may benefit from syphilis/STI screening.	N/A
Primary Syphilis	3 months	Evaluation and presumptive treatment of contacts exposed <i>within 3 months</i> prior to the onset of symptoms or signs in the case patient.
Secondary Syphilis	6 months	Evaluation and presumptive treatment of contacts exposed <i>within 6 months</i> prior to the onset of symptoms or signs in the case patient.
Early Latent Syphilis	12 months Since skin and mucous membrane lesions, which often go unrecognized by patients, occur predominately during the first year of infection, persons diagnosed with early latent syphilis are potentially infectious to contacts despite their lack of symptoms or exam findings at the time of treatment. ²³	Evaluation and presumptive treatment of contacts exposed <i>within 12 months</i> of first serologic evidence of infection or re-infection, in the case-patient.
Late Latent Syphilis	Persons diagnosed with late latent infection (ie, acquired > 1 year prior to treatment) are not considered to be infectious to current/recent sexual or needle-sharing contacts.	Long-term ongoing partners exposed to the case-patient more than 1 year ago may benefit from syphilis screening.
Latent Syphilis of Unknown Duration	If there is insufficient information to determine the duration of latent infection, the case-patient may have been infectious over the past year. Patients with latent syphilis of unknown duration who have high nontreponemal serologic titers (ie, > 1:32) have an increased likelihood of recent acquisition and of being infectious. ²³	Evaluation and presumptive treatment of contacts exposed <i>within 12 months</i> of first serologic evidence of infection, or re-infection in the case-patient.
Ocular, Otic, or Neuro-syphilis	Central nervous system, ocular and otic infection are not sexually transmissible.	If the case-patient also meets the diagnostic criteria for primary, secondary, early latent, or latent of unknown duration, contacts should be managed as noted above.
Tertiary Syphilis	Not considered infectious.	

FAQ: Partner Management

- Primary, secondary, **or** early latent syphilis (not incubation period)
 - Partners exposed in the last 90 days: empiric therapy
- Secondary syphilis
 - Partners exposed 90 days-6 months+ symptom duration: serologies, treat if positive
- Early latent
 - Partners exposed 90 days-12 months: serologies, treat if positive
- Late latent
 - Long term sex partners should be tested, treat if positive
- **Important!!** Patients treated for primary, secondary, or early latent syphilis should abstain from sex until 7 days after they (and partners) start treatment

Summary

- Syphilis case rates are still high!
- Think about testing your patients
 - If vulnerable to infection (take a good history)
 - When screening for other sexually transmitted infections
- Knowing which syphilis testing algorithm is in use at your institution is important for diagnosis and staging
- Treatment is based on the stage of disease
 - Remember to screen for neurologic, ocular, and otic manifestations
- Identifying syphilis cases requires a high index of suspicion

NYC STI Prevention Training Center

The CDC-funded NYC STD Prevention Training Center at Columbia University provides a continuum of education, resources, consultation and technical assistance to health care providers, and clinical sites.

<https://publichealth.columbia.edu/nycptc>

Didactic Presentations

Webinars, conferences, trainings and grand rounds presentations to enhance and build knowledge

Technical Assistance

Virtual and on-site technical assistance regarding quality improvement, clinic implementation and best practices around sexual health provision

For more information please contact:
nycptc@cumc.columbia.edu

Clinical Consultation Warmline

Clinical guidance regarding STD cases; no identifying patient data is submitted

<https://stdccn.org/>

Resources

Clinical guidance tools regarding the STD treatment guidelines, screening algorithms and knowledge books, such as the **Syphilis Monograph**.

To download a copy please visit:

<https://www.publichealth.columbia.edu/file/15568/download?token=exDNYpJ->

