Update on Congenital Syphilis in California

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California Department of Public Health
STD Control Branch

MCAH Action
Folsom, CA

May 18, 2017
Overview

- Summarize epidemiologic trends in STDs in California, including syphilis in women and congenital syphilis
- Describe syphilis stages and natural history
- Review CDC guidelines for screening for syphilis in pregnant women
- Describe characteristics of congenital syphilis cases in California and prevention opportunities
Chlamydia, Incidence Rates by Gender and Age Group (in years)  
California, 2015

Note: Age was “Not Specified” for 0.3% of female cases and 0.3% of male cases for the given year. Since this disease is often asymptomatic, reported cases may reflect chlamydial infections identified through screening programs offered primarily to women.
Chlamydia, Incidence Rates for Females by Race/Ethnicity
California, 2006–2015

Note: NA/AN = Native American/Alaskan Native, A/PI = Asian/Pacific Islander.
Race/ethnicity “Not Specified” ranged from 33.1% to 40.3% of cases for females in any given year.
Chlamydia, Incidence Rates by County, California, 2015

Rate per 100,000
- 0 cases reported
- < 200
- 200 to 299
- 300 to 399
- 400 +
STD Control Branch

Chlamydia among Females Ages 15-24
Incidence Rates by County, California, 2015

Rate per 100,000
- 0 cases reported
- < 1,000
- 1,000 - 1,999
- 2,000 - 2,999
- 3,000 +
Ranking of County Chlamydia Rates among Females Ages 15-24
California, 2015
(with 95% Confidence Intervals*)

Rate per 100,000 population

* Confidence intervals were calculated using Poisson exact method; excludes counties with no cases or statistically unstable rates.

Note: Rates are per 100,000 population.
Source: California Department of Public Health, STD Control Branch
Gonorrhea, California versus United States
Incidence Rates, 1941–2015

Rate per 100,000 population

Year


California
United States

CA=138.9
2014=110.7
(2015 n/a)
Gonorrhea, Incidence Rates by Gender, California, 1995–2016

In 2016, MSM made up 65% of male interviewed cases; 34% of MSM were HIV+ (MSM = Gay, bisexual, and other men who have sex with men).
Gonorrhea, Incidence Rates by Gender and Age Group (in years)
California, 2015

Male

Rate per 100,000

Female

Note: Age was “Not Specified” for 0.4% of female cases and 0.3% of male cases for the given year.
Gonorrhea, Female Incidence Rates by Race/Ethnicity and Age Group (in years), California, 2015

Rate per 100,000 population

11 times white rate
7 times white rate

Age Group
10 - 14 15 - 19 20 - 24 25 - 29 30 - 34 35 - 44 45+

Black Hispanic White
Ranking of County Gonorrhea Rates
California, 2015
(with 95% Confidence Intervals*)

* Confidence intervals were calculated using Poisson exact method; excludes counties with no cases or statistically unstable rates.

Note: Rates are per 100,000 population.
Source: California Department of Public Health, STD Control Branch
Early Syphilis*
California versus United States Incidence Rates, 1941–2016

* Includes primary, secondary, and early latent syphilis.

Provisional data 4.2017
Early Syphilis, Number of Cases by Gender & Gender of Sex Partners, California, 1995–2016

In 2016, MSM made up 72% of male cases; 55% of MSM were HIV+.

Provisional data 4.2017
Early Syphilis*
Incidence Rates by Gender and Age Group (in years)
California, 2016

* Includes primary, secondary, and early latent syphilis.

Provisional data 4.2017
Early Syphilis*, Incidence Rates by County and Gender
California, 2016

* Includes primary, secondary, and early latent syphilis.

Provisional data 4.2017
Ranking of County Early Syphilis* Rates among Females Ages 15-44
California, 2016
(with 95% Confidence Intervals*)

Provisional data 4.2017

* Includes primary, secondary, and early latent syphilis.
† Confidence intervals were calculated using Poisson exact method; excludes counties with no cases or statistically unstable rates.

Note: Rates are per 100,000 population.
Source: California Department of Public Health, STD Control Branch
Early Syphilis*
Incidence Rates for Females by Race/Ethnicity
California, 2006–2015

Note: NA/AN = Native American/Alaskan Native, A/PI = Asian/Pacific Islander.
Race/ethnicity “Not Specified” ranged from 0% to 7.2% of cases for females in any given year.

* Includes primary, secondary, and early latent syphilis.
Methamphetamine Use among Early Syphilis Cases by Sexual Orientation, California, 2007–2016

* Includes primary, secondary, and early latent syphilis.

MSM = Men who have sex w/men, MSW = Men who have sex w/women, MSU = Men of unknown sexual orientation

Provisional data 4.2017
Congenital Syphilis

Rate per 100,000 live births

Year


California

CA=35.6

United States

2015=12.4
(2016 n/a)

2020 Objective
(9.6)

Note: The Modified Kaufman Criteria were used through 1989. The CDC Case Definition (MMWR 1989; 48: 828) was used effective January 1, 1990. California data prior to 1985 include all cases of congenital syphilis, regardless of age.

Provisional data 4.2017

Provisional data 4.2017
Congenital Syphilis Cases by County, California, 2016

Provisional data 4.2017
Primary and Secondary Syphilis — Rates of Reported Cases by State, United States and Outlying Areas, 2015

CA state ranking by rates: #3 overall
- #2 among males (23.0)
- #2 among females (2.4)

NOTE: The total rate of primary and secondary syphilis for the United States and outlying areas (Guam, Puerto Rico, and Virgin Islands) was 7.6 per 100,000 population.

Slide courtesy Dr. Kidd, CDC
Congenital Syphilis — Rates of Reported Cases by Region, United States, 2011–2015

Rate per 100,000 live births

Year

2011 2012 2013 2014 2015

West
South
Midwest
Northeast

Slide courtesy Dr. Kidd, CDC
Congenital Syphilis — Rates of Reported Cases by Region, United States, 2011–2015

Rate per 100,000 live births

California Cases/rate have quadrupled since 2012

Slide courtesy Dr. Kidd, CDC
## Congenital Syphilis — States with Largest Absolute Increases in Reported Cases, United States, 2014–2015

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>461</td>
<td>487</td>
<td>6%</td>
<td>26</td>
</tr>
<tr>
<td>California</td>
<td>102</td>
<td>141</td>
<td>38%</td>
<td>39</td>
</tr>
<tr>
<td>Louisiana</td>
<td>46</td>
<td>53</td>
<td>15%</td>
<td>7</td>
</tr>
<tr>
<td>Georgia</td>
<td>17</td>
<td>21</td>
<td>24%</td>
<td>4</td>
</tr>
<tr>
<td>Oregon</td>
<td>2</td>
<td>6</td>
<td>200%</td>
<td>4</td>
</tr>
<tr>
<td>Illinois</td>
<td>27</td>
<td>30</td>
<td>11%</td>
<td>3</td>
</tr>
<tr>
<td>Nevada</td>
<td>5</td>
<td>8</td>
<td>60%</td>
<td>3</td>
</tr>
<tr>
<td>North Carolina</td>
<td>6</td>
<td>9</td>
<td>50%</td>
<td>3</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>4</td>
<td>7</td>
<td>75%</td>
<td>3</td>
</tr>
<tr>
<td>Tennessee</td>
<td>2</td>
<td>5</td>
<td>150%</td>
<td>3</td>
</tr>
<tr>
<td>Washington</td>
<td>2</td>
<td>5</td>
<td>150%</td>
<td>3</td>
</tr>
</tbody>
</table>
## Congenital Syphilis — States With Highest Number of Cases and Highest Rates per 100,000 Live Births, 2015

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>2015 Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>California</td>
<td>141</td>
</tr>
<tr>
<td>2</td>
<td>Louisiana</td>
<td>53</td>
</tr>
<tr>
<td>3</td>
<td>Texas</td>
<td>49</td>
</tr>
<tr>
<td>4</td>
<td>Florida</td>
<td>38</td>
</tr>
<tr>
<td>5</td>
<td>Illinois</td>
<td>30</td>
</tr>
<tr>
<td>6</td>
<td>Georgia</td>
<td>21</td>
</tr>
<tr>
<td>7</td>
<td>Maryland</td>
<td>18</td>
</tr>
<tr>
<td>8</td>
<td>Ohio</td>
<td>17</td>
</tr>
<tr>
<td>9</td>
<td>Arizona</td>
<td>14</td>
</tr>
<tr>
<td>10</td>
<td>New York</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>2015 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Louisiana</td>
<td>83.9</td>
</tr>
<tr>
<td>2</td>
<td>California</td>
<td>28.5</td>
</tr>
<tr>
<td>3</td>
<td>Maryland</td>
<td>25.0</td>
</tr>
<tr>
<td>4</td>
<td>Nevada</td>
<td>22.8</td>
</tr>
<tr>
<td>5</td>
<td>Illinois</td>
<td>19.1</td>
</tr>
<tr>
<td>6</td>
<td>Florida</td>
<td>16.4</td>
</tr>
<tr>
<td>7</td>
<td>Arizona</td>
<td>16.4</td>
</tr>
<tr>
<td>8</td>
<td>Georgia</td>
<td>16.3</td>
</tr>
<tr>
<td>9</td>
<td>Oregon</td>
<td>13.3</td>
</tr>
<tr>
<td>10</td>
<td>Arkansas</td>
<td>13.2</td>
</tr>
</tbody>
</table>
Syphilis Overview

- Causative organism: *Treponema pallidum*, a spirochete bacterium, that replicates in 30 hours
- Transmitted by intimate skin-to-skin contact
- Causes systemic infection
- Incubation period: 10-90 days
- Characterized by episodes of active disease interrupted by periods of latent infection
- Without treatment, remains chronic or resolves
Syphilis Natural History

<table>
<thead>
<tr>
<th>Stage</th>
<th>Incubation Period</th>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure</td>
<td>30-50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>Incubation Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3-4 weeks</td>
<td>2-6 weeks</td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
<td>25% Possible relapse</td>
</tr>
<tr>
<td>Latent</td>
<td></td>
<td></td>
<td>After 3-8 weeks lesions disappear spontaneously</td>
</tr>
<tr>
<td>Tertiary</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Neurosyphilis can occur at any stage
Syphilis Staging Flowchart

**SIGNS OR SYMPTOMS?**

- **YES**
  - Chancre
  - Rash, etc.

- **NO**
  - LATENT
    - ANY IN PAST YEAR?
      - Negative syphilis serology
      - Known contact to an early case
      - Good history of typical signs/symptoms
      - 4-fold increase in titer
      - Only possible exposure was this year

- **YES**
  - EARLY LATENT (< 1 year)

- **NO**
  - LATE LATENT or UNKNOWN DURATION
Treatment is Based on Duration of Infection

**In pregnancy, must adhere to strict 7 days between doses**

- **PRIMARY, SECONDARY, and EARLY LATENT (< 1 year)**
  - Benzathine penicillin G 2.4 million units IM in a single dose

- **LATE LATENT or UNKNOWN DURATION**
  - Benzathine Penicillin G 2.4 million units once per week for 3 weeks**

CDC 2015 STD Treatment Guidelines
www.cdc.gov/std/treatment
Brief Clinical Overview of Congenital Syphilis
Early Congenital Syphilis (<age 2)

Common Presentations

- Asymptomatic presentations are common
  - ~2/3 infants born with CS are asymptomatic at birth – if untreated will develop symptoms
- Bone abnormalities
- Enlargement of liver +/- jaundice
  - Hepatomegaly present in almost all infants with CS
- Skin rash
- Nasal discharge (“snuffles”)
- Blood abnormalities
- Neurologic abnormalities
- Others
Syphilitic Rash

Photos courtesy of Public Health Image Library, CDC and Dr. Norman Cole.
Late Congenital Syphilis (>age 2) Common Presentations

• Hearing loss (puberty – adulthood).
  – Can develop suddenly
• Interstitial keratitis (5 years old – adulthood)
  – Inflammation of tissue of cornea, can lead to vision loss
• Bone or tooth abnormalities
• Neurologic abnormalities
• Gummas (granulomatous inflammatory response to spirochetes) in the skin or mucous membranes
• Others
Interstitial Keratitis

Photos courtesy of Public Health Image Library, CDC/Susan Lindsley
Hutchinson’s Teeth

Permanent incisor teeth are narrow and notched.

Photos courtesy of Public Health Image Library, CDC/Susan Lindsley (left) and Robert Sumpter Jr.
Perforation of hard palate
Clutton’s Joints

Saber Shins

Photos courtesy of Public Health Image Library, CDC/J. Pledger
Syphilis in Pregnancy and Congenital Syphilis
Screening Recommendations – CDC

- All pregnant women should be screened for syphilis at the first prenatal visit
- Women who are at high risk for syphilis, live in areas of high syphilis morbidity, or are previously untested should be screened again both:
  - Early in the third trimester (approx 28 weeks GA)
  - At delivery

Penicillin treatment of pregnant women with syphilis is highly effective at preventing CS
California Counties with Third Trimester +/- Delivery Syphilis Screening Recommendations for All Pregnant Women, 5/2017

Early Syphilis* among Females of Childbearing Age (15-44) Incidence Rates by County, California, 2016

* Includes primary, secondary, and early latent syphilis.

All 2016 data are provisional.
CDC Screening Recommendations

• No infant should leave the hospital without the maternal serologic status having been determined at least once during pregnancy, and again at delivery if at risk.
  – If mother presents at delivery with no prenatal care, STAT RPR should be performed
  – If baby has congenital syphilis and is asymptomatic, there is still an opportunity to treat the infant to prevent further morbidity

• Any woman who delivers a stillborn infant should be tested for syphilis
Treatment of Syphilis in Pregnancy

- The only treatment of syphilis in pregnancy is penicillin. There are no alternatives.
- Pregnant women should be treated with the penicillin regimen appropriate for their stage of infection.
  - Some experts recommend a 2nd dose of benzathine penicillin G be given a week after the initial dose in early syphilis
- Pregnant women with penicillin allergy should be desensitized and treated with penicillin.

All patients with syphilis should be tested for HIV.
Early Prenatal Care, Screening, & Treatment is 98% Effective

Prevention Impact (%) by Outcome and Study

- Screening (Hawkes 2011)
- Treatment (Blencowe 2011)
- Treatment (Alexander 1999)

| Outcome                  | Impact (%)
|--------------------------|------------
| CS Incidence             | 97%        |
| Stillbirth               | 82%        |
| Perinatal Death          | 80%        |
| Preterm Delivery         | 64%        |
What are common pathways that a woman delivers a baby with CS?

**Woman acquires syphilis prior to pregnancy**

- Not diagnosed, not tested
- Not adequately treated
- SHE BECOMES PREGNANT

**She acquires syphilis during pregnancy**

- Not diagnosed
  - (late to prenatal care or no prenatal care, early screen negative and not repeated, seroconverted after birth)
- Not treated
  - (treatment not ordered, lost to follow up)
- Late to treatment
  - (treatment initiated <30 days prior to delivery)
- Inadequate treatment
  - (wrong drug or dose, lack or delay in 2nd or 3rd shots for late latent syphilis)

RARELY, among those diagnosed and treated:

- Maternal treatment failure
- Fetal demise
- Permanent fetal damage prior to treatment
What do we know about the cases?
California Project Area CS Cases 2007-2015: Infant Characteristics (n=391)

- Stillbirth: 7%
- Signs of CS on exam: 11%
- Long bone abnormalities: 10%
- Reactive CSF VDRL: 9%
- Abnormal CSF: 32%
- Preterm birth: 30%

Credits: Stoltey, Ng
Number of congenital syphilis cases, by maternal stage: Majority of mothers had late syphilis

<table>
<thead>
<tr>
<th>Year</th>
<th>Late syphilis</th>
<th>Early syphilis</th>
<th>Unknown stage</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>22 (61%)</td>
<td>14 (42%)</td>
<td>0 (0%)</td>
<td>36</td>
</tr>
<tr>
<td>2008</td>
<td>11 (42%)</td>
<td>8 (31%)</td>
<td>0 (0%)</td>
<td>26</td>
</tr>
<tr>
<td>2009</td>
<td>17 (61%)</td>
<td>11 (42%)</td>
<td>0 (0%)</td>
<td>28</td>
</tr>
<tr>
<td>2010</td>
<td>10 (50%)</td>
<td>8 (40%)</td>
<td>0 (0%)</td>
<td>20</td>
</tr>
<tr>
<td>2011</td>
<td>11 (56%)</td>
<td>7 (44%)</td>
<td>0 (0%)</td>
<td>18</td>
</tr>
<tr>
<td>2012</td>
<td>13 (61%)</td>
<td>6 (39%)</td>
<td>0 (0%)</td>
<td>23</td>
</tr>
<tr>
<td>2013</td>
<td>12 (62%)</td>
<td>5 (38%)</td>
<td>0 (0%)</td>
<td>20</td>
</tr>
<tr>
<td>2014</td>
<td>14 (65%)</td>
<td>6 (35%)</td>
<td>0 (0%)</td>
<td>70</td>
</tr>
<tr>
<td>2015</td>
<td>20 (63%)</td>
<td>8 (37%)</td>
<td>0 (0%)</td>
<td>120</td>
</tr>
</tbody>
</table>

Credits: Stoltey, Ng
Percent of congenital syphilis cases, by maternal age at delivery: Majority of mothers were ages 20-29
Congenital Syphilis
Incidence Rates per 100,000 (L) and Number of Cases (R) by Race/Ethnicity of Mother, California, 2016

Incidence Rates

Number of Cases
When did mother initiate prenatal care? Over half of mothers initiated prenatal care only in 3rd trimester or not at all

- 1st trimester (n=75, 19.2%)
- 2nd trimester (n=57, 14.6%)
- 3rd trimester (n=63, 16.1%)
- No prenatal care (n=137, 35.0%)
- Unknown (n=14, 3.6%)
- Received prenatal care, outside CA (n=3, 0.8%)
- Received prenatal care, missing info (n=42, 10.7%)

Nationally, 74% initiate in 1st Trimester; only 6% in 3rd Trimester or not at all (CDC, 2011)
Syphilis screening at first prenatal care visit

Among 199 mothers with documented first prenatal visit:

Reasons for delay:
- Provider error
- Lab off-site
- Patient lost to follow-up and labs never drawn
- Surveillance data incomplete

Tested within 7 days of first visit, n=119, 60%

Delayed or not tested, n=80, 40%

Credits: Stoltey, Ng

STD Control Branch
Treatment of mothers accessing prenatal care in 1st/2nd trimester with reactive test ≥ 30 days prior to delivery (n=67)

- Adequately Treated: 31% (n=21)
- Treated Inappropriately: 16% (n=10)
- Not Treated: 15% (n=11)
- Started Treatment < 30 Days Before Delivery: 10% (n=7)
- Unknown Treatment: 10% (n=7)
Maternal risk characteristics for interviewed early syphilis cases (n=92)

70% (92 of 132) interviewed

Risk in 12 months prior to diagnosis

- Methamphetamine use
  - 2007-12 (n=46): 22% (n=10)
  - 2013-15 (n=46): 44% (n=20)

- Exchange of sex for money, drugs
  - 2007-12 (n=46): 6.5% (n=3)
  - 2013-15 (n=46): 13% (n=6)

- Jail, juvenile hall, prison
  - 2007-12 (n=46): 13% (n=6)
  - 2013-15 (n=46): 13% (n=6)
What will it take to eliminate CS?

• Response requires customized strategies

Previous Outbreaks in the U.S.
- Crack cocaine, exchange for sex, NYC 1986-88
- Rural South, South Carolina 1991-1993
- Indian reservation, Arizona 2007-2009
- Chinese birth tourism, Los Angeles 2014

• How can we use the epi data to drive program?
• What additional data would be helpful?
• How do we prioritize congenital syphilis prevention?
• What partnerships should be leveraged?
• How can we measure our effectiveness?
• Are there policy solutions?
Public Health Response: Points of Intervention to Prevent CS

**Pre-pregnancy**
- Screening/dx/tx
- Timely partner services
- Accessible highly effective contraception

**During pregnancy**
- Linkage to prenatal care
- Screening/dx
- Timely treatment appropriate for stage
- Timely partner services
- Case management
- Prevent and detect new infection

**Birth**
- Evaluation and treatment of baby
## Partnerships:
**Shared Responsibility, Aligned Resources**

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Congenital syphilis</td>
<td>MCAH, Birth defects prevention, MTCT of HIV prevention, Health insurance providers, PNC providers, EDs, Corrections, Drug Treatment</td>
</tr>
<tr>
<td>Women</td>
<td>Family planning, pregnancy prevention, MCAH Health insurance providers, Ob/gyns</td>
</tr>
<tr>
<td>Drug users</td>
<td>Corrections CBOs and drug treatment</td>
</tr>
</tbody>
</table>
Congenital Syphilis Prevention Cascade, California Project Area 2007-2014

- Infected with syphilis: 100%
- Received prenatal care in 1st or 2nd trimester: 77%
- Received syphilis testing >= 30 days before delivery: 73%
- Received timely appropriate treatment: 63%

~4x More NON-Pregnant Women with Syphilis

Opportunity for Prevention of Disease and Complications

CS Cases PREVENTED
Congenital Syphilis Prevention

- Clinical
- Policy
- Surveillance/Epidemiology
- Disease Investigation
- Health Promotion
If you would like to customize and distribute within your LHJ, contact Ashley Dockter at ashley.dockter@cdph.ca.gov
Watch Out!
Don't hook-up with syphilis

Syphilis is spreading in our community

Syphilis is a sexually transmitted infection that can have very serious complications when left untreated.

Get Tested. Get Treated.
Call 559-600-3434 for more information
Update for Health Care Providers

CONCERNING INCREASES IN SYphilis IN WOMEN AND CONGENITAL SYphilis:
AN UPDATE FOR CALIFORNIA HEALTH CARE PROVIDERS

THE PROBLEM: INCREASING CONGENITAL SYphilis IN CALIFORNIA
California has had a concerning increase in syphilis among women over the past two years. This has been accompanied by a tripling of congenital syphilis cases from 2012 to 2014. In 2014, most female early syphilis cases and congenital syphilis cases in California were reported from the Central Valley and Los Angeles County. Most women who gave birth to babies with congenital syphilis received prenatal care late in pregnancy or not at all. This increase in numbers of congenital syphilis cases in California is an important public health problem requiring immediate attention from medical providers caring for pregnant women and women of reproductive age.

WHAT IS CONGENITAL SYphilis?
Congenital syphilis occurs when syphilis is transmitted from an infected mother to her fetus during pregnancy. It is a potentially devastating disease that can cause severe illness in babies including premature birth, low birth weight, birth defects, blindness, and hearing loss. It can also lead to stillbirth and infant death.

CONGENITAL SYphilis CAN BE PREVENTED!
Congenital syphilis can be prevented with early detection and 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 diseases (STDs), including syphilis, in women at risk, in addition to access to highly effective contraception.

PRENATAL SCREENING: IT’S THE LAW!
All pregnant women should receive routine prenatal care which includes syphilis testing. In California, it is required by law that pregnant women get tested for syphilis at their first prenatal visit. Syphilis testing should be repeated during the third trimester (28-32 weeks gestational age) and at delivery. Women who are at high risk for syphilis or live in areas with high rates of syphilis, particularly among females, should receive routine risk assessment.

STANDARDIZED TREATMENT GUIDELINES
Treatment for early syphilis is determined by the disease's duration.
- Penicillin doses are the same as those for uncomplicated infections.
- Syphilis treatment guidelines are from the CDC (2015).

SOURCES FOR HEALTH CARE PROVIDERS
- Centers for Disease Control and Prevention (CDC): http://www.cdc.gov/nchstp/stds/hvd/hvd.html

For more information and resources, please visit the CDC website.
Date: March 23, 2016  
To: Medical Care Providers  
From: Alvaro Garza, MD, MPH, Health Officer  
       Julie Vaishampayan, MD, MPH, Assistant Health Officer  

Health Alert  

Ongoing Increase in Syphilis in Women Calls for  
Testing All Pregnant Women in the First & Third Trimester, and at Delivery  

Situation: San Joaquin County is experiencing an increase in heterosexual transmission of syphilis, syphilis in women, and congenital syphilis. In 2015, 57% of syphilis was transmitted through heterosexual contact. Syphilis in women has increased dramatically and now accounts for 29% of all reported syphilis in the county. Six babies were reported with congenital syphilis in 2015 compared to two babies diagnosed with congenital syphilis in 2014. See Figure below.  

The Health Officer is designating San Joaquin County as an area with high syphilis morbidity.  

Such a designation calls for all clinicians to follow best practices and guidelines as established by the CDPH, CDC.
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Syphilis Incidence Increasing Steadily in Monterey County
The Congenital Syphilis Multidisciplinary Case Examination Toolkit

A Prevention Tool for Local STD Programs

This toolkit is intended for use by local health jurisdictions to conduct in-depth multidisciplinary examinations of congenital syphilis cases to identify missed opportunities for prevention and potential upstream interventions to prevent future cases.
STD Control Public Health Response

- Confirm pregnancy status on lab reports (females)
- Prioritization by age, gender, pregnancy status
- Ensure timely treatment of pregnant women
- Contact tracing, partner testing and treatment
- Field testing sexual/social contacts
- Ensure adequate work up and treatment of neonates
Pre-Pregnancy Prevention & Screening Strategies

- Pregnancy prevention (LARC)
- Pregnancy testing
- Drug and mental health treatment
- Venue-based Screening (Corrections*)
- Syphilis screening & treatment in non-pregnant women
- Syphilis screening & treatment of MSW
Screening Adult Females in Correctional Settings: A Promising Approach

INTERVENTION:
→ Qualitative (or STAT) RPR testing → Search syphilis case registry database → Treatment at the time of medical evaluation

OUTCOMES:
• Treatment indicated for 190/760 (26%)
• Increased syphilis treatment from 7% to 84%
• Prevented 7 out of 8 potential congenital syphilis cases because mother was treated before discharge from correctional facility
• Cost: $8,200 to hook up STAT RPR equipment and registry and $0.25 per STAT RPR screening test

How Syphilis Came Roaring Back

The 18th-century ailment was on the brink of elimination before budget cuts helped resurrect it.

Olgakhazan and Russell Berman | Jun 28, 2016 | Health

In recent months, newspapers around the country have published stories that sound like they could have been written 100 years ago. Indiana’s syphilis cases skyrocketed by 70 percent in a single year. Texas’ Lubbock county was under a “syphilis alert.” Various counties face shortages of the medication used to treat syphilitic pregnant women.
Areas for potential synergistic efforts in prevention of congenital syphilis?

• Case management of pregnant women at high risk?
• Outreach to pregnant women who are not accessing prenatal care?
• Alignment with Fetal and Infant Mortality Review in select counties?
• Outreach to delivery hospitals in high-morbidity regions?
• Strengthen health care provider/public health partnership in prevention of congenital syphilis?
• Include information about congenital syphilis in provider education activities?
Take-Home Points: Congenital Syphilis in California

- Female syphilis and congenital syphilis cases are increasing in California.
- Most congenital syphilis cases can and should be prevented.
- What activities, opportunities, and partnerships are available in your local health jurisdiction to assist with congenital syphilis prevention?
- What information can the CDPH STD Control Branch provide that would enhance prevention efforts in your counties?
Clinical Guidelines and Consultation

www.cdc.gov/std/treatment/  
www.std.ca.gov

Clinician Warmline  
510-620-3400  
stdcb@cdph.ca.gov

CDC STD Treatment Guidelines App  
Available now, free

Thanks!  

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