

# Evaluating Patients For Primary Syphilis

## SEXUAL HISTORY, RISK ASSESSMENT, & PHYSICAL EXAM

### Sexual History, Risk Assessment (past year)

- Gender of partners, number of partners (new, anonymous, serodiscordant HIV status, exchange of sex for drugs or money)
- Types of sexual exposure
- Recent STDs; HIV serostatus
- Substance abuse
- Condom use

### History of Syphilis

- Prior syphilis (last serologic test & last treatment)

### Physical Exam

- Oral cavity
- Lymph nodes
- Skin
- Palms & soles
- Neurologic
- Eyes
- Genitalia/pelvic
- Perianal

## DIAGNOSTIC ISSUES IN PRIMARY SYPHILIS

- **Darkfield** ~ 80% sensitive, varies with skill of examiner; decreased sensitivity as lesion ages
- A negative RPR/VDRL does not exclude syphilis diagnosis; ~75-85% sensitive in primary syphilis
- Use same test (RPR or VDRL) in sequential testing; titers are not interchangeable
- Need both non-treponemal (RPR or VDRL) and treponemal test (TP-PA, FTA-ABS, EIA, CIA) to make syphilis diagnosis
- Treponemal tests can remain positive for life; utility limited in patients with history of prior syphilis, comparison of non-treponemal titers needed

### For more details on Treponemal Immunoassays:

[www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/UseofTreponemalImmunoassays\\_Syphilis.pdf](http://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/UseofTreponemalImmunoassays_Syphilis.pdf)

**Note:** Evaluate for neurosyphilis (assess if neurologic, ophthalmic or otic symptoms present, as neurosyphilis can occur at any stage of syphilis)

## TREATMENT & FOLLOW-UP

### Treatment of Primary Syphilis

#### Recommended Regimen

- Benzathine Penicillin G 2.4 million units IM x 1

#### Alternative Regimens for Penicillin Allergic Non-Pregnant Patients:

Efficacy not well established & not studied in HIV+ patients; close follow-up essential:

- Doxycycline 100 mg po bid x 2 weeks or
- Tetracycline 500 mg po qid x 2 weeks

\*Pregnant patients with penicillin allergy should be desensitized and treated with penicillin

See CDC STD Treatment Guidelines: [www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment)

#### California STD Treatment Guidelines Grid:

[www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/STD-Treatment-Guidelines-Color.pdf](http://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/STD-Treatment-Guidelines-Color.pdf)

#### \*\*Additional Testing and Follow-up

**Note:** Also test for HIV, GC/CT, and pregnancy (if female of reproductive age)

- 1-2 weeks: clinical follow-up
- 3, 6, 9, 12, 24 months: serologic follow-up for HIV+ patients
- 6, 12 months: serologic follow-up for HIV- patients
- Failure of titer to decline fourfold (e.g. 1:64 to ≤ 1:16) within 6-12 months from titer at time of treatment may indicate treatment failure. Titer decline may be slower in HIV+ patients.
- Consider retreatment and CSF evaluation if titer fails to decline appropriately

## REPORTING & PARTNER MANAGEMENT

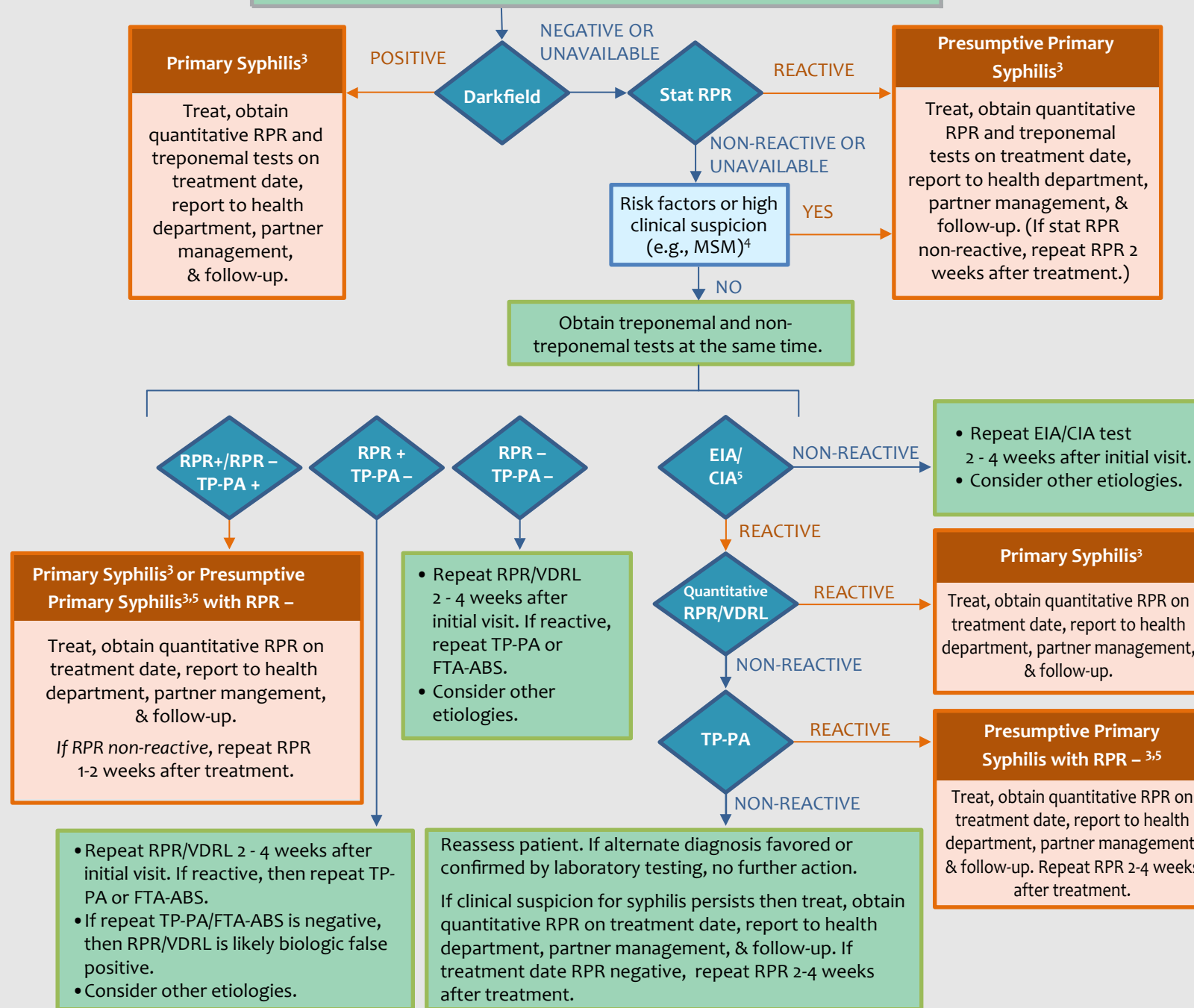
- All syphilis cases and presumptive cases must be reported to the local health department within one working day of diagnosis
- Local health departments will assist in partner notification & management
- Contact Number at Local Health Department:

Patient with new genital lesion or suspicious genital ulcer

## SEXUAL HISTORY, RISK ASSESSMENT, & PHYSICAL EXAM

### DIAGNOSTIC WORK-UP

- Darkfield (if available)
- Stat RPR (if available)
- RPR or VDRL serology (quantitative)
- Treponemal test<sup>1</sup> (TP-PA/FTA-ABS/EIA/CIA)
- Herpes culture or PCR<sup>2</sup>
- HIV Test



## CLINICAL PRESENTATIONS OF PRIMARY SYPHILIS

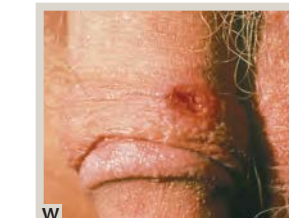
- Lesion appears 10-90 days after contact at site of exposure; may persist for 2-3 weeks then resolves
- Usually genitoretal but may be extragenital, depending on exposure site
- Clinical presentation, typical or atypical
- Typical: single painless, indurated, clean-based ulcer with rolled edges & bilateral painless adenopathy
- Atypical: can mimic herpes & other genital ulcers
- ~25% present with multiple lesions
- Lesions of primary and secondary syphilis can be present at the same time, especially in HIV positive individuals

### Differential Diagnosis

- Herpes (most common), primary HIV ulcers, chancroid, granuloma inguinale, trauma, and many non-STD infectious and non-infectious causes of genital ulcers
- More than one etiology can be present at the same time



Syphilitic Ulcer, Shaft



Syphilitic Ulcer, Shaft



Multiple Syphilitic Ulcers, Shaft



Multiple Syphilitic Ulcers Resembling Herpes



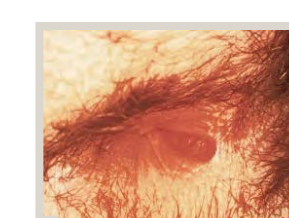
Syphilitic Ulcer, Vulva



Multiple Syphilitic Ulcers, Vulva



Crusted Syphilitic Ulcer, Urethra



Syphilitic Ulcer, Perianal

### Photo Credits

C - Centers for Disease Control and Prevention; D - With permission from the Denver Metro Health Clinic; S - With permission from San Francisco City Clinic; W - With permission from University of Washington STD Prevention Training Center Washington (photos from UW HSCER Slide Bank)

### To Order Additional Copies

See the online version of the Primary Syphilis Algorithm on the clinical resources page of the CA PTC website: [www.californiaptc.com](http://www.californiaptc.com)

### Acknowledgements

Medical Directors from the National Network of STD Clinical Prevention Training Centers, California STD Controllers Association, Division of STD Prevention of the Centers for Disease Control and Prevention

Revised 7/2018

<sup>1</sup> Treponemal tests may be more sensitive than non-treponemal tests during primary syphilis.

<sup>2</sup> Also consider culture for Haemophilus ducreyi (chancroid) if exposure in endemic areas or if lesion does not respond to syphilis treatment.

<sup>3</sup> All patients with suspected syphilis should be tested for HIV infection and screened for other STDs. Repeat HIV testing of patients with primary syphilis 3 months after the first HIV test, if the first test is negative.

<sup>4</sup> If the patient is a man who has sex with men (MSM) or has high risk sexual behavior or clinical exam with classic features of a syphilitic ulcer, then standard of care includes presumptive treatment at the time of the initial visit before diagnostic test results are available. Presumptive treatment is also recommended if patient follow-up is a concern.

<sup>5</sup> If the patient does not respond to treatment, repeat RPR/VDRL after treatment and consider other etiologies.