May 1, 2003

FROM:

STD & Hepatitis Prevention Program
Public Health Services
Health Human Services Agency
County of San Diego

Contents -- STD Hepatitis Update No. 8
Syphilis Outbreak Continues

Attachments

- **Alert about inadvertent use of Bicillin® C-R for treatment of Syphilis. The correct formulation is Benzathine Penicillin (Bicillin® L-A)**
- **Flier – Emerging Issues in STD and HIV Prevention and Care Conference – May 23, 2003, Marina del Rey**

Syphilis Outbreak Continues

Reported Cases

During the first quarter of 2003 (Jan – Mar), 35 infectious syphilis cases (primary or secondary stage) were reported in San Diego County compared to 38 cases reported for the entire year of 2002. Of these 2003 cases, 32 were gay men/men who have sex with men (MSM). Adding these 32 cases to the 16 cases reported in the last quarter (Oct – Dec) of 2002 (all of whom were MSM), a total of 48 MSM infectious-stage syphilis cases have been reported in the past 6 months. Importantly, 59% of these infectious syphilis patients were also HIV-infected. Numerous studies have shown that STDs, especially syphilis, facilitate HIV transmission.

Primary Syphilitic Lesion

- **Location –** Primary syphilis is the most infectious stage of syphilis and probably accounts for 90% of syphilis transmission. Among MSM, the primary chancre lesion (which is usually painless) **can sometimes be occult** – located in the anal canal, rectum, or oral cavity.

- **Description –** A syphilitic chancre is usually a single, painless, firm, clean-based ulcer with rolled borders. **However, atypical presentations are common.** Currently, among MSM, **any genital, anal, rectal or oral ulcer should be considered as presumptive primary syphilis unless another diagnosis is clearly more likely.**

- **Diagnosis –** A confirmed primary syphilis diagnosis can be made by identifying characteristic *T. pallidum* by darkfield examination of serous fluid expressed from the ulcer. Alternatively, the same fluid can be placed on a slide, air-dried and submitted to the county Public Health Laboratory for a direct fluorescent antibody (DFA-TP)

examination. Call the Laboratory at 619-692-8500 for assistance or 619-692-8501 for Field Services assistance. In addition, darkfield examination can be obtained by sending the patient to the main STD clinic; call Field Services (619-692-8501) to help arrange the clinic visit.

- **Treatment –** Clinically suspect primary syphilis should be presumptively treated with **2.4 million units of benzathine penicillin (Bicillin L-A).** It is important to use the correct formulation of penicillin so that low levels of antibiotic are maintained for 3-4 weeks. Bicilllin C-R is not appropriate (see attached detailed descriptions of penicillin preparations). For patients allergic to penicillin, azithromycin 2.0 gm in a single dose or doxycycline 100 mg b.i.d. x 14 days are alternative treatments**. When using non-penicillin treatments, close clinical and serologic follow-up is indicated.**

- **Serology –** Obtain a serologic specimen for RPR or VDRL on all suspect primary syphilis cases. If positive, the laboratory should then run a confirmatory test (TP-PA, FTA, MHA-TP). For lesions < 7 days old, please request a confirmatory test to be done even if the screening test is negative, **since occasionally the confirmatory test is positive before the screening test.**

- **Serologic tests during the first 7 days –** Patients with classical symptomatic lesions <7 days in duration may have negative serologic tests. If treated during that time period, the tests may never turn positive. The **final diagnosis is made clinically;** epidemiologic data may be supporting (infection documented in sex partner[s]).

- **Partner Services –** Clinically diagnosed primary syphilis should be reported to the STD Control Program (619-692-8501) as soon as the diagnosis is suspected so that partner services can be initiated. The objective of partner services is to preventively treat exposed sex partners who may be in the incubation stage and, thus, abort development of infectious syphilis. Such persons will remain serologically negative.

- **Reporting –** California Code of Regulations (Title 17, Section 2500) mandates that physicians having evidence of a **SUSPECT CASE OF PRIMARY SYPHILIS (or any stage)** should report to the local health department within 1 working day by phone or fax. **Please do not wait for serologic test results before reporting clinically suspect primary syphilis.**

Identifying occult primary syphilis among MSM

- **Stage at Diagnosis –** Two-thirds of the infectious-stage syphilis cases among MSM are being reported in the secondary stage (body rash, etc.), indicating that the case patient passed through the very infectious primary stage (usually lasts 3 weeks) undetected.

- **Risk Assessment –** High-risk MSM (men having multiple anonymous partners) should have a risk assessment frequently (every visit). They should be questioned about anal and oral symptoms, visually examined when indicated, and serologically tested.

- **Serologic Testing –** In light of the current outbreak, we recommend syphilis serologic screening every 2-3 months, or even monthly among MSM if high-risk sexual behavior is ongoing. A low titer RPR/VDRL may be indicative of occult primary lesion rather than a late infection acquired years ago.