Utah Department of Health & Human Services

Congenital syphilis

Background

Recently, there has been a sharp increase in the number of infants born with syphilis in the U.S. Utah is no exception to this concerning trend as there were 6 times as many congenital syphilis cases in 2022 compared with 2018. Fortunately, congenital syphilis is preventable. Providers who care for pregnant patients are important partners in the fight against the rise in congenital syphilis. Information on maternal screening, treatment, follow up, and infant evaluation is listed below.

1 Screening pregnant patients

- Per Utah law, all pregnant patients should be screened for syphilis at their first prenatal visit.
- Recently, The American College of Obstetricians and Gynecologists updated their recommendations to also screen all pregnant patients during the third trimester and again at delivery, regardless of risk factors.
- Screening may be done using either the traditional or reverse syphilis testing algorithms (see CDC guidelines). Regardless of the algorithm used, positive results should be followed up with confirmatory testing.

2 Maternal treatment

- Pregnant patients with syphilis must be treated with Bicillin. In the case of penicillin allergy, they should work with a specialist to be desensitized and treated with Bicillin.
- Treatment for pregnant patients must be started at least 30 days before delivery to prevent infection in their infant.
- People who have primary, secondary, or early latent syphilis require 1 dose of 2.4 mu Bicillin.
- People who have late latent syphilis require 3 weekly doses of 2.4 mu Bicillin. These doses should be 7 days apart, however up to 9 days is acceptable for pregnant patients.
- If a dose is missed or falls outside of the 9-day range, treatment must be restarted.
- If patients experience neurological symptoms of syphilis, they must be treated with an IV penicillin course. See details in the CDC treatment guidelines.

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3 Maternal follow up

- Coordinated prenatal care and documented treatment are important.
- If a pregnant patient is treated at/before 24 weeks' gestation, wait at least 8 weeks to repeat RPR testing unless they have new symptoms.
- RPR testing should be repeated for all pregnant patients at delivery.
- Post-treatment RPR titer response varies widely during pregnancy. Many patients do not have a fourfold decrease (e.g., 1:8 to 1:2) by delivery.
- A fourfold increase (e.g., 1:4 to 1:16) could indicate reinfection or neurosyphilis. Pregnant patients with a fourfold increase in titer should be reevaluated and treated.

4 Previous infections

- If a pregnant patient has been diagnosed with syphilis somewhere other than Utah, work with your local health department to get their testing and treatment history.
- Without proof of appropriate treatment, a pregnant patient must be treated again for the current stage of infection.
- If a pregnant patient's records are outside the U.S., they need to get their own records if possible. If these are not available, they will need to be treated again.
- An infant born to a mother who tests positive for syphilis and does not have documented treatment should be managed as a congenital syphilis case.

5 Infant evaluation and follow up

- All infants born to mothers who tested positive for syphilis during pregnancy should be tested with an RPR and examined for symptoms of congenital syphilis.
- The CDC guidelines list 4 different congenital syphilis scenarios based on the mother's testing and treatment. Each scenario provides evaluation and treatment recommendations.
- Infants with a positive RPR test at birth should receive follow up testing every 2–3 months until the test becomes negative.
- Infants with a negative RPR test at birth should be retested at age 3 months to rule out incubating congenital syphilis at the time of birth.
- Refer to the CDC guidelines for how to interpret and manage follow up test results.