SYphilis

Syphilis is a chronic systemic infection caused by the spirochete *Treponema pallidum*. This sexually transmitted, genital ulcerative disease causes significant complications if untreated, and facilitates the transmission of HIV. Untreated syphilis in pregnant women results in perinatal death in up to 40% of cases and, if acquired during the four years preceding pregnancy, may lead to infection of the fetus in 80% of cases. Although the rate of primary and secondary (P&S) syphilis in the United States declined 89% between 1990 and 2000, the rate of P&S syphilis increased annually between 2001 and 2008. These increases were primarily among men (increasing from 3.0 cases per 100,000 population to 7.6 cases per 100,000 population). After persistent declines from 1992 to 2003, the rate of P&S syphilis among women increased from 0.8 cases per 100,000 population in 2004, to 1.5 cases per 100,000 population in 2008. The rate of P&S syphilis is highest in persons aged 20-24 years and 25-29 years (11.4 and 10.7 cases per 100,000 population, respectively). Syphilis remains an important problem in the South and in urban areas in other U.S. regions.

**Figure 7** Average rates of syphilis for U.S. men and women of different age ranges for the years 2004-2008.

In 2008 California ranked tenth among 50 States; Washington, DC; and three territories in P&S syphilis rates, with 6 cases per 100,000 population. The rate among males was 11.4 per 100,000 population while the rate among females was 0.6 per 100,000. In California, the race/ethnicity adjusted rates per 100,000 population were: 6.2 among whites, 15.1 among blacks, 5.6 among Hispanics, 2.2 among Asian/Pacific Islanders, and 3.0 among American Indians/Alaska Natives. In 2008, the rate of P&S syphilis in Los Angeles County was 8.3 per 100,000.
After declining for 14 years, the congenital syphilis rate in the United States among infants aged <1 year increased 23%, from 8.2 cases per 100,000 live births, in 2005, to 10.1 in 2008. This increase followed a 38% increase in the P&S syphilis rate among females aged ≥10 years between 2004 and 2007. During 2005-2008, congenital syphilis rates increased primarily in the South (from 9.6 per 100,000 live births to 15.7) and among infants born to black mothers (from 26.6 per 100,000 live births to 34.6). The figure below shows the congenital syphilis rate among infants aged <1 year, and rate of P&S syphilis among females aged ≥10 years.

**Figure 8** Primary and Secondary Syphilis Among Women age 10 and above and Rates of Congenital Syphilis among infants under age 1 year.

Figure 9 Rates of Primary and Secondary Syphilis and Congenital Syphilis in California

California, 2008

Primary and secondary syphilis
- CASES: California reported 2,204 cases in 2008.
- RATES: California ranked 10 among 50 states; Washington, DC; and 3 territories with 6 cases per 100,000 population compared to the U.S. rate of 4.5 cases per 100,000 population.

Rates of primary and secondary syphilis, by sex
- In California, the rate among males was 11.4 per 100,000 population compared to the U.S. male rate of 7.8 per 100,000.
- The rate among females was 0.6 per 100,000 compared to the U.S. female rate of 1.5 per 100,000.

Rates of primary and secondary syphilis, by race/ethnicity
- In California, the race/ethnicity adjusted rates per 100,000 population were 6.2 among whites, 15.1 among blacks, 5.6 among Hispanics, 2.2 among Asian/Pacific Islanders, and 3.0 among American Indians/Alaska Natives.
- The rate among blacks was 2.4 times that of whites.

Congenital syphilis
- CASES: California reported 62 cases in 2008.
- RATES: California ranked 12 among 26 states; Washington, DC; and 1 territory reporting congenital syphilis cases with a rate of 11.0 cases per 100,000 live births compared to the U.S. rate of 10.1 cases per 100,000.
Complications in Pregnancy

Pregnancy does not have an effect on the clinical course of syphilis. On the other hand, syphilis adversely affects pregnancy, and untreated syphilis may cause spontaneous abortion, nonimmune hydrops, preterm delivery, IUGR, stillbirth, and perinatal death or long-term morbidity. The incidence of congenital syphilis reflects the rate of syphilis in women of childbearing age. Many congenital syphilis cases develop because the mother had no prenatal care, no penicillin treatment, or inadequate treatment before or during pregnancy. Among women with untreated early syphilis, 40% of pregnancies result in spontaneous abortion.

The risk of congenital syphilis is directly related to the stage of syphilis in the mother, and the risk is extremely high for the first four years after maternal acquisition of infection. Maternal P&S syphilis are associated with a 50% probability of congenital syphilis and a 50% rate of perinatal death; early latent disease, with a 40% risk of congenital syphilis and a 20% perinatal mortality rate; and late latent syphilis, with a 10% risk of congenital syphilis. Transplacental transmission can occur at any time during gestation, even as early as 6 weeks, but typically occurs during the second half of pregnancy.35,45

Screening

All pregnant women should be screened for syphilis at their first prenatal visit. In populations with a high prevalence of syphilis, like Los Angeles County, or for patients at high risk (i.e., drug use, multiple sexual partners, history of STDs), repeat serologic testing should take place at 28-32 weeks gestation and at delivery.35 The CDC also suggests that any woman delivering a stillborn after 20 weeks’ gestation be screened for syphilis. Furthermore, no infant should be discharged from the hospital without knowing the maternal serologic status.35

Diagnosis

The most specific and sensitive method of diagnosing syphilis is demonstration of T. pallidum in fresh specimens obtained from the lesions of infected individuals with primary or secondary syphilis. Darkfield examination and direct fluorescent antibody tests are the definitive methods of diagnosing early syphilis.

The majority of women who are diagnosed with syphilis are asymptomatic and in the latent stage. Therefore, a presumptive diagnosis is based on the use of two types of serologic tests: A nontreponemal test, such as VDRL (Venereal Disease Research Laboratory) or RPR (rapid plasma reagin), is used for screening because the test is sensitive but not specific. These tests are inexpensive, rapidly performed, and provide quantitative results, which are helpful indicators of disease activity, and are used to monitor response to treatment. If the nontreponemal test is positive, confirmatory testing is performed with a specific treponemal test, such as the microhemagglutination test for T. pallidum (MHA-TP) or the fluorescent treponemal antibody absorption (FTA-ABS). These latter tests are not quantitative and, once positive, will remain so for life, even after successful treatment.
The risk of congenital syphilis is directly related to the stage of syphilis in the mother, and the risk is extremely high for the first four years after maternal acquisition of infection.

Clinical Manifestations of Syphilis

Virtually all new syphilis infections are sexually acquired, except for cases of congenital syphilis resulting from vertical transmission (i.e., acquired in utero or during delivery). Syphilis is very efficiently transmitted during sexual contact in the early stages of disease (P&S syphilis); 50-60% of partners are infected following a single exposure to an infected individual. Transmission requires exposure to open lesions in which organisms are present. The spirochetes enter the new host through any break in the skin or via microscopic tears in mucosal surfaces of the genital tract. The incubation period averages 21 days (10-90 day range).

Primary syphilis The first manifestation of syphilis is a papule which is typically painless at the site of inoculation. This soon ulcerates to produce the classic chancre of primary syphilis, a 1-2 cm painless ulcer with a raised, indurated margin. The ulcer is typically associated with bilateral regional lymphadenopathy. Chancres heal spontaneously within 3-6 weeks, even without treatment, and typically do not leave a scar.

Secondary syphilis Secondary syphilis is a disseminated systemic disease that begins 6 weeks to 6 months after the appearance of the chancre in 25% of untreated patients. A nonpruritic, bilaterally symmetrical, generalized maculopapular skin rash involving the palms and soles and mucous membranes but usually sparing the face is characteristic of this stage of infection. Generalized lymphadenopathy accompanies the skin rash. Additional clinical features include malaise, fever, pharyngitis, anorexia, myalgias, arthralgias, alopecia, and large genital lesions called condylomata lata. The alopecia is characterized by patchy hair loss of the scalp and facial hair, including eyebrows. Condylomata lata are painless, highly infectious, gray-white raised plaques located on adjacent folds of skin in moist areas. The rash of secondary syphilis resolves spontaneously within 2-6 weeks.

It is important to recognize that when the syphilitic chancre first appears, both the nonspecific antibody tests and the treponemal-specific tests will be nonreactive. However, within 4-6 weeks of the chancre’s appearance, they will both be positive. Similarly, both nontreponemal and treponemal tests will be universally positive during secondary and latent stages of syphilis. In pregnancy, it is best to consider seropositive women infected unless an adequate treatment history is documented in the medical record and sequential serologic antibody titers have declined.

False positive reactions can occur with all of these tests, but are uncommon with the specific antitreponemal tests. Causes of false positive nontreponemal tests include: viral infections, autoimmune diseases, narcotic abuse, leprosy, malaria, pinta/yaws, recent immunizations, and pregnancy. The false-positive tests with nontreponemal tests are usually only weakly positive or borderline reactions.

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The risk of congenital syphilis is directly related to the stage of syphilis in the mother, and the risk is extremely high for the first four years after maternal acquisition of infection.
Latent syphilis Following resolution of the rash of secondary syphilis, the patient enters the latent phase in which there are no clinical manifestations of disease. Individuals with primary, secondary, or early latent (up to one year) syphilis have replicating treponemal organisms and are capable of transmitting syphilis to susceptible hosts. On the other hand, syphilis is rarely transmitted during the late latent (>one year) phase, with the exception of perinatal transmission during pregnancy. The risk of congenital syphilis is directly related to the stage of syphilis in the mother, and the risk is extremely high for the first four years after maternal acquisition of infection when spirochetemia is present in pregnancy.

Tertiary syphilis Without therapy about one third of patients develop tertiary syphilis that is characterized by slowly progressive damage to the central nervous system (neurosyphilis), cardiovascular system, or musculoskeletal system and/or involvement of various organ systems, with granulomatous lesions called gummas. Such manifestations usually develop 5 to 20 years after the disease became latent. The pathogenesis of tertiary syphilis is based on tropism of \textit{T. pallidum} for arterioles, resulting in obliterative endarteritis and subsequent tissue destruction.

For illustrations of selected clinical findings, please see \url{http://www2a.cdc.gov/stdtraining/ready-to-use/Manuals/Syphilis/syphilis-slides-handouts-2009.pdf}. If the link does not connect please go to \url{www.cdc.gov} and search for “syphilis slides”.

| Table 9 Summary of Clinical Manifestations of Syphilis |
|---------------------------------|--------------------------------------------------|
| **Stage**                      | **Clinical Manifestations**                      |
| Primary syphilis               | Painless ulcer (chancre) at site of inoculation, adenopathy |
| Secondary syphilis             | Rash, mucocutaneous lesions, adenopathy, hepatitis, arthritis, glomerulonephritis, patchy alopecia, condyloma lata |
| Latent syphilis                | Asymptomatic                                    |
| • Early latent (<1 year after infection) |                                                                 |
| • Late latent (>1 year after infection) |                                                                 |
| Tertiary syphilis             | Gummatous lesions, Aortic aneurysm, aortic insufficiency, Tabes dorsalis, Argyll-Robertson pupils, paresis, seizures, subtle psychiatric manifestations, dementia. May be asymptomatic |
| • Cutaneous                    |                                                                 |
| • Cardiovascular disease       |                                                                 |
| • Central nervous system (neurosyphilis) |                                                                 |

Congenital syphilis Two-thirds of live-born neonates with congenital syphilis are asymptomatic at birth and do not develop evidence of active disease for 3-8 weeks. Overt infection can manifest in the fetus, the newborn, or later in childhood. Clinical manifestations after birth are divided arbitrarily into early (≤2 years of age) and late (>2 years of age). The stigmata of late congenital syphilis result from scarring induced by early lesions or reactions to persistent inflammation.
Table 10 Summary of Clinical Manifestations of Congenital Syphilis

<table>
<thead>
<tr>
<th>Clinical Manifestations</th>
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<tbody>
<tr>
<td><strong>Fetus</strong></td>
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<tr>
<td>Hydrops fetalis, stillbirth (25% of affected infants); perinatal mortality (50%)</td>
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<tr>
<td><strong>Early congenital syphilis</strong></td>
</tr>
<tr>
<td>IUGR, reticuloendothelial abnormalities, mucocutaneous lesions, bone abnormalities,</td>
</tr>
<tr>
<td>ocular abnormalities, CNS abnormalities</td>
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<tr>
<td><strong>Late congenital syphilis</strong></td>
</tr>
<tr>
<td>Neurologic abnormalities, dental abnormalities, skeletal abnormalities, facial</td>
</tr>
<tr>
<td>abnormalities</td>
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</table>
## GUIDELINES FOR SYphilis IN PREGNANCY

### Table 11 Key Principles of Best Practices for Screening, Treatment and Follow-up for Syphilis in Pregnancy

<table>
<thead>
<tr>
<th>Screening</th>
<th>Treatment</th>
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</table>
| ● Screen all pregnant women for syphilis with either VDRL or RPR at the first PNV.  
● Rescreen pregnant women from a high prevalence population or at high risk for acquiring a sexually transmitted infection at 28-32 weeks’ gestation and again at delivery. | ● Parenteral penicillin G is the preferred drug for treating all stages of syphilis. The preparation used (benzathine, aqueous procaine, or aqueous crystalline), the dosage and length of treatment depend on the stage and clinical manifestations of the disease.  
● Parenteral penicillin G is the only therapy with documented efficacy for syphilis during pregnancy.  
● Pregnant women with syphilis at any stage who report penicillin allergy should be desensitized and treated with penicillin.  
● The Jarisch-Herxheimer reaction is an acute febrile reaction frequently accompanied by headache, myalgia, and other symptoms that usually occur within the first 24 hours after any therapy for early syphilis. This reaction may precipitate preterm labor or cause fetal distress in pregnant women, but this should not prevent or delay therapy. | See CDC guidelines for treatment |

### Diagnosis

- If the screening test is positive, promptly have a quantitative nontreponemal test and a confirmatory treponemal test performed.
- Inquire whether the patient was ever treated for syphilis and attempt to obtain those records from the local public health department.
- Syphilis is a reportable disease

### Follow-up

- Repeat quantitative nontreponemal serologic tests (VDRL or RPR) at 6, 12, and 24 months.
- Consider retreatment if titers increase fourfold or if an initially high titer (>1:32) fails to decline at least fourfold (i.e., two dilutions) within 12-24 months of therapy.
- In pregnancy, ensure that clinical and antibody responses are appropriate for the stage of syphilis. However, most women will deliver before their serologic response to treatment can be determined definitively.
- Monthly serologic titers may be necessary for women at high risk for re-infection or in regions with high prevalence;
- Maternal treatment is considered inadequate if:
  - Birth occurs within 30 days of treatment,
  - Clinical signs of syphilis are present at time of birth;
  - Maternal antibody titer at birth is fourfold higher than pretreatment titer
Table 12 CDC Recommended Treatments for Syphilis in HIV-Negative Adults

| Primary & Secondary Syphilis                      | Benzathine penicillin G 2.4 million units IM in a single dose |
| Early Latent Syphilis*                           | Benzathine penicillin G 2.4 million units IM in a single dose |
| Late Latent Syphilis or Latent Syphilis of Unknown Duration* | Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals |
| Tertiary Syphilis**                              | Benzathine penicillin G 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals |
| Neurosyphilis                                    | Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV every 4 hr or continuous infusion, for 10-14 days OR Procaine penicillin 2.4 million units IM once daily PLUS Probenecid 500 mg po qid, both for 10-14 days |

*Persons with latent syphilis should be evaluated for evidence of tertiary disease (e.g., aortitis and gumma) and syphilitic ocular disease (e.g., iritis and uveitis). Patients who have syphilis and who demonstrate any of the following should have a prompt cerebrospinal fluid (CSF) examination:

- Neurology or ophthalmic signs or symptoms,
- Evidence of active tertiary syphilis,
- Treatment failure, or
- HIV infection with late latent syphilis or syphilis of unknown duration

**Patients with symptomatic tertiary syphilis should have a CSF examination before therapy is initiated.

Management of Sexual Partners

Sexual transmission of *T. pallidum* occurs only when mucocutaneous syphilitic lesions are present; such manifestations are uncommon after the first year of infection. However, persons exposed sexually to a patient with syphilis in any stage should be evaluated clinically and serologically, and treated with a recommended regimen, according to the recommendations outlined in Figure 10.
Management of Sexual Partners of Adults Diagnosed with Syphilis

Identification of At-Risk Sexual Partners
All those with sexual contact within
- 3 months plus duration of symptoms for primary syphilis
- 6 months plus duration of symptoms for secondary syphilis
- 1 year for early latent syphilis

Key Components of Evaluation
- History
- Clinical exam
- Syphilis serology
- HIV serology & other STI testing
- Follow-up: 6 & 12 mos. Plus 24 months (for latent or unknown duration)

Exposure

≤ 90 days of partner diagnosed with:
- Primary
- Secondary or
- Early Latent

Evaluation
- Presumptive Treatment even if serology is negative
- Positive Clinical Exam
  - Treat
  - Follow-up if serology is positive
- Negative Clinical Exam
  - Treat if serology is positive
  - Pts. Serologic Results Immediately Available
    - Yes: Presumptive Treatment
    - No: Follow-up is certain

Benzathine penicillin G
2.4 million units IM in a single dose

Management & Follow-up:
- Counseling
- Reporting
- Contact tracing

Follow-up: If uncertain that follow-up will be complete, may require more frequent visits than those listed
- For Primary, Secondary and Early Latent: Repeat Clinical and Serologic evaluation at 6 and 12 months post treatment;
- For Latent or Unknown duration: repeat clinical and serologic testing at 24 months as well;
Non-treponemal test titers are expected to decline fourfold within 6 to 12 months after treatment. If titers do not decline, retest for HIV and consult for optimal management.

Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines — MMWR 2010:59(RR-12)
PATIENT EDUCATIONAL MATERIALS

In this section you will find examples of patient education materials for syphilis in pregnancy.

Please also consult the links below for the most up-to-date patient education materials.

<table>
<thead>
<tr>
<th>Centers for Disease Control and Prevention</th>
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<tbody>
<tr>
<td><strong>Patient Handout- Syphilis - The Facts</strong> Available in English and Spanish</td>
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<tr>
<td><strong>Syphilis Fact Sheet</strong></td>
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<tr>
<td><strong>STDs In Pregnancy Fact Sheet</strong></td>
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<th>California STD/HIV Prevention Training Center</th>
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<tr>
<td><strong>Syphilis Fact Sheet</strong></td>
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<tr>
<th>American Congress of Obstetricians and Gynecologists</th>
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<tr>
<td><strong>Gonorrhea, Chlamydia and Syphilis Fact Sheet</strong></td>
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<tr>
<th>American Academy of Family Physicians</th>
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<tr>
<td><strong>Sexually Transmitted Diseases- Fact Sheets</strong></td>
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<tr>
<th>Medline Plus-US National Library of Medicine, National Institutes of Health</th>
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<tr>
<td><strong>Syphilis Facts</strong></td>
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What is syphilis?
Syphilis is a sexually transmitted disease (STD) caused by the bacterium Treponema pallidum. It has often been called “the great imitator” because so many of the signs and symptoms are indistinguishable from those of other diseases.

How common is syphilis?
In the United States, health officials reported over 36,000 cases of syphilis in 2006, including 9,756 cases of primary and secondary (P&S) syphilis. In 2006, half of all P&S syphilis cases were reported from 20 counties out of 2 cities; and most P&S syphilis cases occurred in persons 20 to 39 years of age. The incidence of P&S syphilis was highest in women 20 to 24 years of age and in men 35 to 39 years of age. Reported cases of congenital syphilis in newborns increased from 2005 to 2006, with 339 new cases reported in 2005 compared to 349 cases in 2006.

Between 2005 and 2006, the number of reported P&S syphilis cases increased 11.8 percent. P&S rates have increased in males each year between 2000 and 2006 from 2.6 to 5.7 and among females between 2004 and 2006. In 2006, 64% of the reported P&S syphilis cases were among men who have sex with men (MSM).

How do people get syphilis?
Syphilis is passed from person to person through direct contact with a syphilis sore. Sores occur mainly on the external genitalia, vagina, anus, or in the rectum. Sores also can occur on the lips and in the mouth. Transmission of the organism occurs during vaginal, anal, or oral sex. Pregnant women with the disease can pass it to the babies they are carrying. Syphilis cannot be spread through contact with toilet seats, doorknobs, swimming pools, hot tubs, bathtubs, shared clothing, or eating utensils.

What are the signs and symptoms?
Many people infected with syphilis do not have any symptoms for years, yet remain at risk for late complications if they are not treated. Although transmission occurs from persons with sores who are in the primary or secondary stage, many of these sores are unrecognized. Thus, transmission may occur from persons who are unaware of their infection.

Primary Stage: The primary stage of syphilis is usually marked by the appearance of a single sore (called a chancre), but there may be multiple sores. The time between infection with syphilis and the start of the first symptom can range from 10 to 90 days (average 21 days). The chancre is usually firm, round, small, and painless. It appears at the spot where syphilis entered the body. The chancre lasts 3 to 6 weeks, and it heals without treatment. However, if adequate treatment is not administered, the infection progresses to the secondary stage.

Secondary Stage: Skin rash and mucous membrane lesions characterize the secondary stage. This stage typically starts with the development of a rash on one or more areas of the body. The rash usually does not cause itching. Rashes associated with secondary syphilis can appear as the chancre is healing or several weeks after the chancre has healed. The characteristic rash of secondary syphilis may appear as rough, red, or reddish brown spots both on the palms of the hands and the bottoms of the feet. However, rashes with a different appearance may occur on other parts of the body, sometimes resembling rashes caused by other diseases. Sometimes rashes associated with secondary syphilis are so faint that they are not noticed. In addition to rashes, symptoms of secondary syphilis may include fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, and fatigue. The signs and symptoms of secondary syphilis will resolve with or without treatment, but without treatment, the infection will progress to the latent and possibly late stages of disease.

Late and Latent Stages: The latent (hidden) stage of syphilis begins when primary and secondary symptoms disappear. Without treatment, the infected person will continue to have syphilis even though there are no signs or symptoms; infection remains in the body. This latent stage can last for years. The late stages of syphilis can develop in about 15% of people who have not been treated for syphilis,
and can appear 10-20 years after infection was first acquired. In the late stages of syphilis, the disease may subsequently damage the internal organs, including the brain, nerves, eyes, heart, blood vessels, liver, bones, and joints. Symptoms and signs of the late stage of syphilis include difficulty coordinating muscle movements, paralysis, numbness, gradual blindness, and dementia. This damage may be serious enough to cause death.

- How does syphilis affect a pregnant woman and her baby?
The syphilis bacterium can infect the baby of a woman during her pregnancy. Depending on how long a pregnant woman has been infected, she may have a high risk of having a stillbirth (a baby born dead) or of giving birth to a baby who dies shortly after birth. An infected baby may be born without signs or symptoms of disease. However, if not treated immediately, the baby may develop serious problems within a few weeks. Untreated babies may become developmentally delayed, have seizures, or die.

- How is syphilis diagnosed?
Some healthcare providers can diagnose syphilis by examining material from a chancre (infectious sore) using a special microscope called a dark-field microscope. If syphilis bacteria are present in the sore, they will show up when observed through the microscope.

A blood test is another way to determine whether someone has syphilis. Shortly after infection occurs, the body produces syphilis antibodies that can be detected by an accurate, safe, and inexpensive blood test. A low level of antibodies will likely stay in the blood for months or years even after the disease has been successfully treated. Because untreated syphilis in a pregnant woman can infect and possibly kill her developing baby, every pregnant woman should have a blood test for syphilis.

- How are syphilis and HIV linked?
Genital sores (chancres) caused by syphilis make it easier to transmit and acquire HIV infection sexually. There is an estimated 2- to 5-fold increased risk of acquiring HIV if exposed to that infection when syphilis is present.

Ulcerative STDs that cause sores, ulcers, or breaks in the skin or mucous membranes, such as syphilis, disrupt barriers that provide protection against infections. The genital ulcers caused by syphilis can bleed easily, and when they come into contact with oral and rectal mucosa during sex, increase the infectiousness of and susceptibility to HIV. Having other STDs is also an important predictor for becoming HIV infected because STDs are a marker for behaviors associated with HIV transmission.

- What is the treatment for syphilis?
Syphilis is easy to cure in its early stages. A single intramuscular injection of penicillin, an antibiotic, will cure a person who has had syphilis for less than a year. Additional doses are needed to treat someone who has had syphilis for longer than a year. For people who are allergic to penicillin, other antibiotics are available to treat syphilis. There are no home remedies or over-the-counter drugs that will cure syphilis. Treatment will kill the syphilis bacterium and prevent further damage, but it will not repair damage already done.

Because effective treatment is available, it is important that persons be screened for syphilis on an ongoing basis if their sexual behaviors put them at risk for STDs.

Persons who receive syphilis treatment must abstain from sexual contact with new partners until the syphilis sore is completely healed. Persons with syphilis must notify their sex partners so that they also can be tested and receive treatment if necessary.

- Will syphilis recur?
Having syphilis once does not protect a person from getting it again. Following successful treatment, people can still be susceptible to re-infection. Only laboratory tests can confirm whether someone has syphilis. Because syphilis sores can be hidden in the vagina, rectum, or mouth, it may not be obvious that a sex partner has syphilis. Talking with a healthcare provider will help to determine the need to be re-tested for syphilis after being treated.

- How can syphilis be prevented?
The surest way to avoid transmission of sexually transmitted diseases, including syphilis, is to abstain from sexual contact or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to be uninfected.

Avoiding alcohol and drug use may also help prevent transmission of syphilis because these activities may lead to risky sexual behavior. It is important that sex partners talk to each other about their HIV status and history of other STDs so that preventive action can be taken.

Genital ulcer diseases, like syphilis, can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of syphilis, as well as genital herpes and chancroid, only when the infected area or site of potential exposure is protected.

Condoms lubricated with spermicides (especially Nonoxynol-9 or N-9) are no more effective than other lubricated condoms in protecting against the transmission of STDs. Use of condoms lubricated with N-9 is not recommended for STD/HIV prevention. Transmission of an STD, including syphilis, cannot be prevented by washing the genitals, urinating, and/or douching after sex. Any unusual discharge, sore, or rash, particularly in the groin area, should be a signal to refrain from having sex and to see a doctor immediately.

- FOR MORE INFORMATION:
  Division of STD Prevention (DSTD)
  Centers for Disease Control and Prevention
  http://www.cdc.gov/std/
  CDC INFO Contact Center
  1-800-222-STD (1-800-222-7832)
  Email: cdcinfo@cdc.gov
  American Social Health Association (ASHA)
  1-800-789-9877
  www.ashastd.org

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¿Qué es la sífilis?
La sífilis es una enfermedad de transmisión sexual (ETS) causada por la bacteria Treponema pallidum. A menudo se le ha llamado “la gran imitadora” porque muchos de sus signos y síntomas no se distinguen fácilmente de otras enfermedades.

¿Qué tan frecuente es la sífilis?
En los Estados Unidos, las autoridades de salud registraron más de 36,000 casos de sífilis en el 2006, de los cuales 9,756 eran de sífilis primaria y secundaria. Asimismo, la mitad de todos los casos de sífilis primaria y secundaria en el 2006 se reportaron en 20 condados y 2 ciudades, y en su mayoría correspondían a personas de 20 a 39 años de edad. La incidencia más alta de sífilis primaria y secundaria se registró en mujeres de 20 a 24 años de edad y en hombres de 35 a 39 años. Los casos de sífilis congénita reportados en recién nacidos aumentaron de 339 casos nuevos en el 2005 a 349 en el 2006.

Entre el 2005 y el 2006, el número de casos reportados de sífilis primaria y secundaria aumentó en un 11.8%. Entre el 2000 y el 2006 las tasas de sífilis primaria y secundaria en hombres se incrementaron anualmente de 2.6 a 5.7, mientras que en las mujeres esto mismo ocurrió entre el 2004 y el 2006. En el 2006, el 64% de los casos reportados de sífilis primaria y secundaria correspondieron a hombres que tienen relaciones sexuales con hombres (HSH).

¿Cómo se contrae la sífilis?
La sífilis se pasa de una persona a otra a través del contacto directo con una úlcera sífilítica. Las úlceras aparecen principalmente en los genitales externos, la vagina, el ano o el recto. También pueden salir en los labios y en la boca. La transmisión de la bacteria ocurre durante las relaciones sexuales vaginales, anales u orales. Las mujeres embarazadas que tienen esta enfermedad pueden pasársela a los bebés que llevan en el vientre. La sífilis no se propaga por el contacto con los inodores, las manijas de las puertas, las piscinas, las bañeras normales o de hidromasaje, ni por compartir ropa o cubiertos.

¿Cuáles son los signos y síntomas?
Muchas personas que tienen sífilis no presentan síntomas durante años, pero a menudo enfrentan el riesgo de tener complicaciones en la fase avanzada si no se tratan la enfermedad. Las personas que están en la fase primaria o secundaria de la enfermedad transmiten la infección aunque muchas veces las úlceras sífilíticas no se puedan reconocer. Por lo tanto, las personas que no saben que están infectadas pueden contagiar la enfermedad.

Fase primaria: La fase primaria de la sífilis suele estar marcada por la aparición de una sola úlcera (llamada chancro), pero puede que haya muchas. El tiempo que transcurre entre la infección por sífilis y la aparición del primer síntoma puede variar de 10 a 90 días (con un promedio de 21 días). Por lo general, el chancro es firme, redondo, pequeño e indoloro. Aparece en el sitio por donde la sífilis entró al organismo. El chancro dura de 3 a 6 semanas y desaparece sin ser tratado. Sin embargo, si no se administra el tratamiento adecuado la infección avanza a la fase secundaria.

Fase secundaria: La fase secundaria se caracteriza por erupciones en la piel y lesiones en las membranas mucosas. Esta fase suele comenzar con la aparición de una erupción de la piel en una o más áreas del cuerpo, que por lo general no produce picazón. Las erupciones de la piel asociadas a la sífilis secundaria pueden aparecer cuando el chancro se está curando o varias semanas después de que se haya curado. La erupción característica de la sífilis secundaria puede tomar el aspecto de puntos rugosos, de color rojo o marrón rojizo, tanto en la palma de las manos como en la planta de los pies. Sin embargo, en otras partes del cuerpo también pueden aparecer erupciones de aspecto distinto, o que son similares a las causadas por otras enfermedades. Algunas veces, las erupciones asociadas a la sífilis secundaria son tan leves que pasan desapercibidas. Además, puede que se presenten otros síntomas durante la fase secundaria de la sífilis, como fiebre, inflamación de los ganglios linfáticos, dolor de garganta, caída del cabello en algunas áreas, dolor de cabeza, pérdida de peso, dolores musculares y fatiga. Los signos y síntomas de la sífilis secundaria desaparecen aun si no se tratan, pero si no se administra tratamiento la infección progresará a la fase latente y posiblemente hasta la última fase de la enfermedad.

Fases latente y terciaria: La fase latente (oculta) de la sífilis comienza con la desaparición de los síntomas de las fases primaria y secundaria. Sin tratamiento, la persona infectada seguirá teniendo sífilis aunque no presente signos o síntomas ya que la infección permanece en el cuerpo. Esta fase latente puede durar años. En el 15% de las personas que no reciben tratamiento para la sífilis, la enfermedad puede avanzar hasta las fases latente y terciaria, que pueden aparecer de 10 a 20 años después de haberse adquirido la infección.

En esta fase avanzada la sífilis puede afectar posteriormente órganos internos como el cerebro, los nervios, los ojos, el corazón, los vasos sanguíneos, el hígado, los huesos y las articulaciones.
Los signos y síntomas de la fase terciaria de la sífilis incluyen dificultad para coordinar los movimientos musculares, parálisis, entumecimiento, ceguera gradual y demencia. El daño puede ser grave y causar la muerte.

■ ¿Qué efectos tiene la sífilis en la mujer embarazada y en su bebé?
La bacteria de la sífilis puede infectar al bebé durante el embarazo. Dependiendo de cuánto tiempo una mujer embarazada ha estado infectada, puede enfrentar un alto riesgo de tener un bebé que nazca muerto o de dar a luz un bebé que muere poco después de haber nacido. Un bebé infectado puede que nazca sin los signos y síntomas de la enfermedad. Sin embargo, si no es sometido a tratamiento de inmediato, el bebé puede presentar serios problemas al cabo de unas cuantas semanas. Si estos bebés no reciben tratamiento, pueden sufrir de retraso en el desarrollo, convulsiones o morir.

■ ¿Cómo se diagnostica la sífilis?
Algunos médicos pueden diagnosticar la sífilis mediante el análisis de una muestra líquida del chancre (la úlcera infecciosa) en un microscopio especial llamado microscopio de campo oscuro. Si las bacterias de la sífilis están presentes en la úlcera, se observarán en el microscopio.

Otra manera de determinar si una persona tiene sífilis es mediante un análisis de sangre. Poco después de que una persona se infecte comienza a producir anticuerpos contra la sífilis que pueden ser detectados mediante una prueba de sangre segura, precisa y económica. El cuerpo presentará niveles bajos de anticuerpos en la sangre durante meses o incluso años después de que se haya completado el tratamiento de la enfermedad. Dado que la sífilis no tratada en una mujer embarazada puede infectar y probablemente provocar la muerte de su bebé, toda mujer embarazada debe hacerse un análisis de sangre para detectar la sífilis.

■ ¿Cómo se relaciona la sífilis con el VIH?
Las úlceras genitales (chancros) producidas por la sífilis hacen que sea más fácil contraer la infección por el VIH y transmitirla por vía sexual. Se calcula que el riesgo de contraer la infección por el VIH es 2 a 5 veces mayor cuando la persona expuesta al virus tiene sífilis.

Las ETS ulcerosas que producen llagas, úlceras o rupturas de la piel o de las membranas mucosas, tales como la sífilis, rompen las barreras que protegen contra las infecciones. Las úlceras genitales producidas por la sífilis pueden sangrar fácilmente y cuando entran en contacto con la mucosa bucal o rectal durante la relación sexual aumentan las probabilidades de infección y la susceptibilidad al VIH. El tener otras ETS también puede ser un factor importante para predecir una posible infección por el VIH, ya que las ETS son un marcador de las conductas asociadas a la transmisión del VIH.

■ ¿Cuál es el tratamiento para la sífilis?
La sífilis es fácil de curar en sus fases iniciales. Si una persona ha tenido sífilis durante menos de un año, la enfermedad se curará con una sola inyección intramuscular de penicilina, que es un antibiótico, y si ha tenido sífilis por más de un año, necesitará dosis adicionales. Existen otros antibióticos para tratar la sífilis en personas que son alérgicas a la penicilina. La sífilis no puede curarse con remedios caseros ni con medicinas que se venden sin receta médica. El tratamiento matará la bacteria que causa la sífilis y evitará futuras lesiones, pero no remediará las lesiones ya ocasionadas.

Ya que existe un tratamiento eficaz contra la sífilis, es importante que periódicamente las personas se hagan las pruebas de detección de esta enfermedad si practican conductas sexuales que las ponen a riesgo de contraer ETS. Las personas que están tratándose contra la sífilis deben abstenerse de tener contactos sexuales con parejas nuevas hasta que las úlceras sífilíticas se hayan curado por completo. Las personas que tienen sífilis deben avisar inmediatamente a sus parejas para que se sometan a pruebas y reciban tratamiento si es necesario.

■ ¿La sífilis es recurrente?
El hecho de que una persona haya tenido sífilis una vez no la protege de tenerla de nuevo. Una persona puede seguir siendo susceptible a la reinfección aun cuando se haya curado con el tratamiento. Solamente las pruebas de laboratorio pueden confirmar si una persona tiene sífilis. Dado que las úlceras sífilíticas pueden estar ocultas en la vagina, el recto o la boca, puede ser que una persona no se entere de que su pareja sexual tiene sífilis. El médico le ayudará a determinar si es necesario hacer nuevas pruebas de detección de la sífilis después de que haya concluido el tratamiento.

■ ¿Cómo puede prevenirse la sífilis?
La manera más segura de evitar contraer enfermedades de transmisión sexual, incluida la sífilis, es abstenerse del contacto sexual o tener una relación estable y mutuamente monógama con una pareja que se haya hecho las pruebas y que se sabe que no tiene ninguna infección.

Abstenerse de consumir alcohol y drogas puede también ayudar a evitar la transmisión de la sífilis, ya que estas actividades pueden llevar a una conducta sexual peligrosa. Es importante que las parejas sexuales hablen entre ellas sobre si tienen el VIH o si en el pasado han tenido otras ETS, de manera que puedan tomar acciones preventivas.

Las enfermedades genitales ulcerosas, como la sífilis, pueden aparecer tanto en las áreas genitales masculinas como las femeninas que hayan estado cubiertas o protegidas con un condón de látex, así como en áreas que no estuvieron cubiertas durante la relación sexual. El uso correcto y hábil de los condones de látex puede reducir el riesgo de contraer sífilis, herpes genitales y chancros, solamente si el área infectada o el área de posible contacto está cubierta.

Los condones lubricados con espermicidas (especialmente el Nonoxynol-9 o N-9) no son más eficaces para prevenir la transmisión de las ETS que los otros condones lubricados. El uso de condones lubricados con N-9 no se recomienda para prevenir la infección de las ETS o del VIH. La transmisión de una ETS, incluida la sífilis, no puede prevenirse con lavarse los genitales, orinar o darse una ducha vaginal después de la relación sexual. Cualquier secreción, úlcera o irritación anormal, en particular en el área de la infección, debe considerarse como una señal para dejar de tener relaciones sexuales y consultar al médico de inmediato.

■ PARA OBTENER MÁS INFORMACIÓN:
División de Prevención de Enfermedades de Transmisión Sexual (DSTSD)
Centros para el Control y la Prevención de Enfermedades
http://www.cdc.gov/std/
Centro de información de los CDC
1-800-232-4636 (1-800-232-4636)
Correo electrónico: stdinfo@cdc.gov
Asociación Americana de la Salud Social
(American Social Health Association, ASHA)
1-800-783-9877
www.ashastd.org

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Syphilis Fact Sheet

Syphilis (Si-fil-liss) is a Sexually Transmitted Disease (STD) caused by a type of bacteria called *Treponema pallidum*. Syphilis can infect men, women, and newborns.

Q: How is syphilis spread?
A: Syphilis is spread from person to person during vaginal, oral, or anal sex. A pregnant woman can pass syphilis to her baby.

Q: What are the signs and symptoms of syphilis?
A: Some people do not get any symptoms when they have syphilis.

Symptoms of PRIMARY STAGE SYphilis: (10 to 90 days after becoming infected):
- A skin sore called a chancre (shank-er)
  - Chancres are typically round, firm, and not painful. They are usually on the penis, scrotum, vaginal lips, anus, or mouth.
- Women may not notice the painless sores because they can be inside the vagina.
- Lymph glands near the sore may be swollen but are usually not painful.

**EVEN WITHOUT TREATMENT, THESE SORES WILL GO AWAY -- BUT YOU ARE STILL INFECTED!**

Symptoms of SECONDARY STAGE SYphilis may develop after the primary stage. Symptoms of secondary syphilis are different from person to person.
- Skin rash, which can be widespread all over the body: the rash can be on the palms of the hands and soles of the feet, and is usually not itchy. Sometimes the rash can be hard to notice.
- Bumps (like warts) or flat, white patches in the mouth, on the genitals, or in the rectal area
- Flu-like illness with sore throat, headache, and fever
- Patchy hair loss on the head (not balding)
- Nervous system symptoms are rare but possible. They include headaches, hearing loss, and visual changes.

**EVEN WITHOUT TREATMENT, THESE SYMPTOMS WILL GO AWAY -- BUT YOU ARE STILL INFECTED!**

Q: Is syphilis serious?
A: Yes! Without treatment, syphilis can cause brain damage, blindness, heart disease, and other health problems. These health problems may take 5 to 20 years or more to develop.
- A pregnant woman can pass syphilis to her unborn baby, causing serious illness or death. If you are pregnant or think you may be pregnant, be sure to tell your doctor or nurse.
- A person with an open sore caused by syphilis has a greater chance of giving or getting HIV, the virus that causes AIDS.
Q: How is syphilis treated?
A: • Your doctor or nurse will give you medicine that cures syphilis infection.
  • If you have syphilis, your partner(s) must be treated, even if they have no symptoms.
  If they are not treated, they can give the infection back to you, or infect others.
  • Your health care provider will give you medicine to cure syphilis infection.
  • If you are pregnant or think you may be pregnant, be sure to tell your doctor or nurse.
  • Ask your doctor about the need for follow-up tests.

Q: How do I avoid getting syphilis?
A: ■ Abstinence (not having sex) is the only sure way to avoid infection.
■ Plan Ahead: Think about protecting yourself. Talk with your sex partner(s) about STDs and the need
  to protect yourself. Then, you can choose not to have sex (abstinence), or decide to:
  ■ Use a male condom with each sex partner.
  ■ Use a female condom when a male condom cannot be used.

HIV IS ALSO A STD!
When you catch syphilis, you could also be getting HIV.
Birth control pills or a birth control shot cannot protect you against syphilis or other STDs.

■ USING LATEX CONDOMS CORRECTLY EVERY TIME YOU HAVE SEX CAN REDUCE THE CHANCE
FOR TRANSMISSION OF SYPHILIS ONLY IF THE INFECTED AREAS ARE COVERED OR PROTECTED BY
THE CONDOM.

Q: Where can I get more information about STDs and referrals for STD testing?
A: • Phone: Talk to a trained operator who can answer your questions and provide information about
  STD testing. In English and Español 24 hours/day, 7 days/week: Toll-free: 1-800-CDC-INFO
  (1-800-232-4636); TTY for the Deaf and Hard of Hearing: 1-888-232-6348

  • Internet: Centers for Disease Control and Prevention: http://www.cdc.gov/std/
  http://www.cdc.gov/std/healthcomm/fact_sheets.htm

Talk to your own health care provider, or call your county health department by looking for the
telephone number in the phone book (white pages) under county government. Ask to speak to
someone in the STD clinic or STD program for more information about syphilis.