Policy statement
All Southern Health patients will receive clinical care that reflects best practice and is based on the best available evidence.

Purpose and Rationale
The aim of screening is to detect and treat pregnant women who are infected with syphilis, and thereby prevent long term complications in the mother, transmission to sexual partners and congenital syphilis. This is important as congenital syphilis may result in stillbirth, premature birth, neonatal death and severe infant morbidity.

Scope
Pregnant women booked to birth at Southern Health.

Definitions
Syphilis
- Infection with the spirochaete, Treponema pallidum.

Early syphilis
- May be primary, secondary or early latent syphilis (under 2 years from acquisition if previous negative test available). Early latent syphilis is considered potentially infectious due to the possibility of mucocutaneous relapses.

Late latent syphilis
- Late latent syphilis is defined as latent syphilis (over 2 years from acquisition) or syphilis of unknown duration (if no prior test is available) in the absence of tertiary syphilis.

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1. Diagnosing syphilis

Syphilis infection may be asymptomatic and detected by abnormal serology (latent syphilis) or manifest with clinical signs and symptoms (primary, secondary or tertiary syphilis). In the setting of pregnancy it is most often diagnosed with abnormal serology in an asymptomatic woman during recommended antenatal screening.

Southern Health laboratory performs a Treponema pallidum antibody (TPA) enzyme immunoassay test as an initial screening test. If this test is positive, further testing is performed at a reference laboratory: treponemal specific tests (TPHA, FTA-Abs) and non-specific test (RPR).

It is important to be aware that the treponemal specific tests (TPHA, FTA-Abs) remain positive for life, even after successful treatment, and cannot be used to monitor response to therapy. The non-specific tests (e.g. RPR) may represent false positives, and are less likely to detect latent infection, but can be quantitative and used to monitor response to therapy in early syphilis.

Seropositive women should be considered infected unless adequate treatment history is documented and
Background

Referral to Infectious Diseases is indicated unless the patient has clear documentation of previous adequate treatment and no risk factors for re-infection.

## 2. Treating syphilis

Pregnant women are treated with the same penicillin dosage schedule as non-pregnant patients at a similar stage of disease. The penicillin regimen depends on the likely stage of syphilis infection.

Other antibiotics suitable for use in pregnancy that have been used to treat syphilis in non-pregnant patients include azithromycin.\(^1,2\) In non-pregnant patients 2g azithromycin was as effective as benzathine penicillin.\(^3\) Given the small numbers and lack of evidence for its use in latent syphilis or syphilis of indeterminate duration there is insufficient evidence to recommend it as an alternative to penicillin at this time.

## 3. Jarisch - Herxheimer Reaction

In pregnancy, the incidence of the reaction when treating syphilis, is about 40%.

[www.patient.co.uk/doctor/Jarisch-Herxheimer-Reaction.htm](http://www.patient.co.uk/doctor/Jarisch-Herxheimer-Reaction.htm)

The reaction starts between 1 and 12 hours after the first injection of antibiotics and lasts for a few hours or up to a day. It is not seen with subsequent treatment. There may be malaise, slight-to-moderate pyrexia, a flush due to vasodilation, tachycardia, and leukocytosis. Any existing skin lesions become more prominent. Hyperventilation and tachycardia are accompanied by hypertension, and then by a drop in blood pressure due to vasodilation and declining peripheral resistance. In some patients with early syphilis, a secondary rash may become visible which was absent before treatment. Usually, the reaction resolves over a period of 6 to 12 hours.

### References


Syphilis in pregnancy - diagnosis and management

Keywords or tags

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Disclaimer

The maternity clinical practice procedures and guidelines have been developed having regard to general circumstances. It is the responsibility of every clinician to take account of both the particular circumstances of each case and the application of these procedures and guidelines. In particular, clinical management must always be responsive to the needs of the individual woman and particular circumstances of each pregnancy.

These procedures and guidelines have been developed in light of information available to the authors at the time of preparation. It is the responsibility of each clinician to have regard to relevant information, research or material which may have been published or become available subsequently. Please check this site regularly for the most current version.