Diagnosing Primary Syphilis (Question 4)
• Send RPR, treat for syphilis regardless of result and repeat RPR in 2 weeks [CA]
• Answer to # 4 depends on the clinical picture, ulcer appearance, etc. Always get RPR, may or may not rx on the spot. [GA]
• Send RPR and Tx if suspicious lesion and recent exposure to new partner. [GA]
• Also sometimes send RPR and treat for syphilis only if RPR is positive, depending on h/x. [NV]
• #4 a problem - what does the ulcer look like; are there vesicles?; is there a history of HSV; any GUD outbreaks in the community? [NY]
• Send RPR & treat regardless of results, OR send RPR and if neg repeat or send FTA before deciding whether to treat. [OR]
• Treat if FTA-Ab+ and RPR is positive - hospital. If in STD clinic, tx presumptively. [MO]
• May refer to local clinic with Darkfield or treat if unable to confirm along with RPR. [WI]
• I think you should have gotten more clinical input into putting together this survey. For question no. 4, for example, it's all about risk assessment. If I saw a 38 yo MSM with this presentation, of course I'd treat presumptively for syphilis. In other situations, I might not. [WA]
• Sometimes send RPR and, if neg, repeat in several weeks before deciding whether to treat. [MD]
• Other-do FTA-abs and treat if positive. [FL]

Laboratory Testing Comments
• RPR titers seem to have shifting sensitivities based on apparently different labs and test methods. [LA]
• Our institution has recently changed to a syphilis serology screen test instead of the RPR. This has created problems with interpretation of a positive serology screen, but a negative RPR. This is mostly an issue with our HIV+ patients. Has anyone else reported this? [PA]
• The big issue of late has been the new serologic tests; it's not easy to evaluate a new test without a good gold standard for comparison. We have moved to an EIA. Our lab does RPR as a reflex if EIA is positive. If the EIA is positive and RPR negative, we use TP-PA as a "tiebreaker." I think this is a better approach than using RPR as a screening method, but it is more complicated, and has been confusing for the primary care physicians. Absent any authoritative recommendations on interpreting these results, we have developed guidelines for our system, and I have spent a lot of time educating the docs on how to deal with these tests. [CA]
• Recently, a new testing strategy was implemented at our University lab with a specific anti-treponemal assay used first, then reflex RPR with titer if negative. This process has complicated the testing protocol resulting in more false positive evaluations. [MN]
• The most interesting thing about syphilis these days is the use of the new treponemal EIAs. [CA]
• I would rec. questions that include the complexity of current testing that includes automated ELISA-type testing. [TX]
• Our local lab is now doing treponema IgG/IgM assay which is causing lot of confusion among primary care providers? [IA]

Secondary Syphilis and Decision to do LP (Question 8)
• The duration of pos RPR in secondary syphilis makes a difference in my decision to do LP or not for HIB. If less than one year I do not do LP but if unknown or over one year regardless of CD4 I do recommend LP. [CA]
• Syphilis is very common. I have a low threshold for LP and IV treatment in HIV patients. [NC]
• Many of my patients are highly averse to lumbar puncture. In patients who have advanced HIV infection and are simultaneously found to have a positive RPR, I have focused my attention on establishing rapport with the patient and pushing for compliance with anti-retroviral therapy. Sometimes this has meant not pushing as hard for the lumbar puncture. [NC]
• Because CSF VDRL is insensitive, and HIV patients may have abnormal CSF exams without syphilis, and we are not sure of the significance of pos CSF exam in the setting of 2nd syphilis; I do not do LPs at this stage. Only if RPR does not come down or goes back up or CNS signs. [VT]
• LP in community practice is difficult to arrange. I would only do for very high titer HIV positive pt (1:64) AND/OR with any neuro-ophthalmologic changes including headache. Reinfefted (syphilis) HIV patients seem to be common. I usually give them all the benefit of any doubt and readily retreat. Fortunately, resistance to PCN is not a problem, yet. [AZ]
• I do wonder about the utility of LP in patients without neurologic symptoms, non-PCN allergic and RPR <1:16, HIV-infected or not. And the, what if only the protein is elevated, but the rest of the CSF parameters are normal? MHATP on CSF? [TX]
• Very relevant questions as I've faced these scenarios over past year and not always comfortable I know right answer! Q6: favor 1:8 or less. Q7: favor 1:4 or less. Q8: Have opted not to LP with this exact scenario and have done LP with 1:32 and no neuro Sx. [WI]
• Although I haven't had any syphilis cases in the past year, I've been consulted on syphilis a lot over the years. I'm fairly liberal about performing LPs on patients with syphilis and get a MHA-TP on the CSF to R/O CNS syphilis. While not useful to diagnosis CNS syphilis because of its high sensitivity and concerns about false positives due to blood contamination during the procedure, a negative MHA-TP essentially excludes the disease. [MD]
• Guidelines could be more explicit re: recommendations for LP in HIV-infected and HIV-uninfected patients, including clearly indicating when data are insufficient for a recommendation. [CA]
• We perform lumbar puncture on any HIV pt with syphilis of unknown duration or failure to significantly improve by RPR titers [NC]
• I won't LP if there is obvious optic neuritis or another condition that requires IV PCN. I don't LP at the end of therapy if things are going well. [OH]
• For question 7, in an HIV-infected patient, I would ALWAYS do an LP (if pt agrees) if non-treponemal titer doesn't change. [MD]
• As I review and discuss the "guidelines" for obtaining an LP in late syphilis, I find they can be interpreted with an option to defer the LP IF the follow-up RPR can be shown improved by 6 months. The option appears to be at the discretion of the physician, and takes into consideration his ability to easily offer an LP as well as his assessment of the patient's risk of being lost to follow-up. The readily available guidelines don't appear to discuss the pro's and con's of the options for LP's. [CA]
• I feel there are a number of gray areas in regards to what titer an LP is appropriate at. [IN]
• Much variability in our group practice regarding threshold to do LP in patients co-infected with syphilis (non-primary) and HIV. While this shouldn't be the case, I find my threshold for recommending an LP varies by the setting the consult occurs and any logistical barriers to LP. [PA]
• In question 8, I was unable to check the box "uncertain" under CD4 count of 550. "yes" is not the answer I wanted to give. [CT]
• This survey does little to educate about the frequency of CNS invasion of T. pallidum, nor does it emphasize the divergence between the public health initiative to reduce syphilis transmission vs. the personal health issue of acquiring neurosyphilis and receiving an ineffective treatment (benzathine penicillin). It would have been good to ask questions about the frequency of CNS invasion in primary and secondary syphilis. A follow-up survey about assessing CSF findings in syphilis would be informative. [CA]

“Serofast” RPR Titors (Questions 6-7)
• HIV patients are more vulnerable to other sites of syphilis. Recent experience with retinitis/dms and asymptomatic dms proven in 2-long-time partners (MSM). Both treated with resolution with High dose Pen G x 3 weeks. Very slow decrease in RPR titer but still positive after 3 years of follow up. [FL]
• I have followed several HIV patients over the past several years who seem to be "serofast" with titers in the 1:4 to 1:32 range whose wu for neurosyphilis is negative and whose titers don't seem to change with treatment. In fact, for HIV patients to develop negative RPRs after treatment seems to be the exception rather than the rule. [VA]
• I have an elderly male patient with AIDS on HAART tx (CD4 counts between 150-350 and fairly consistent undetectable viral loads) with and ESRD on hemodialysis with high RPR titers of 1:32-1:64 (as low as 1:16 and as high as 1:128) since 2002 and I have done LP at least 3 times which were negative but have treated him at least 3 times with IV Pen G x 14 days followed by Benzathine Pen G 2.4 MU IM weekly x 3 weeks and now have him on chronic Doxycycline therapy and most recent titer 1:32. I truly do not think this patient is being re-infected. He recently developed hearing loss which I suspect is related also to his syphilis. Anybody have any thoughts?? [MS]
• Re Q7a & 7b: "follow all" [PA]
• Clearer guidelines are needed on following the serofast patient whether HIV+ or HIV negative. We have seen several cases of neurosyphilis in HIV pts recently but they had neurological symptoms. [DC]
• For both questions 6 and 7; if well documented early latent syphilis, ie a negative RPR within the previous 12 months, I would retreat if there is not at least a two fold titre change in 12 months assuming the baseline titre is => 1:2 [FL]
• I am a little confused by questions 6 and 7. I am interpreting the questions to say that 12 mos after treatment, the baseline RPR was unchanged. [GA, MO]
• Questions 6 and 7 are confusing. If the patient's titer has NOT CHANGED 12 months after treatment, then they are a treatment failure (unless you are suggesting that they came in with a very low titer and the initial diagnosis was in question). For HIV patients, in general I try to follow the published guidelines (which are the same for HIV and non-HIV patients), but just follow the patients much more closely and have a lower threshold advance to more aggressive treatment (on a case by case basis). [CA]
• I don't understand questions 6&7. If the patient were treated for early latent syphilis, presumably they had at least some titer, and if it were unchanged after a year, then "non-reactive" wouldn't be an option. I've never seen an early latent patient with a titer of only 1:1. For any other titer, there is no titer I'd be happy with if it hadn't fallen after a year - I'd do an LP and retreat. [MO]
• I worked in an STD clinic for many years, but only see inpatients at this time. However, for question #6 and 7, we often identified serofast patients and titers were very occasionally as high as 1:64. However, we should also acknowledge that not all patients report re-exposures accurately. I would need to see the TREND in titer prior to making the decision about re-treatment or LP (the questions suggest no interval results are available). [MA]
Syphilis and Pregnancy

- I have recommended penicillin desensitization for pregnant patients - sometimes has been done. [CA]
- Penicillin-allergic pregnant patient and syphilis is a complicated situation in clinical practice [CT]
- Need guidelines for serofast status in pregnancy: Do we need to re-treat patients with stable or intermittent RPR positivity (1:1) assuming possible re-exposure? Do all require LP and if they refuse LP and prefer treatment with IV penicillin, do we need follow up RPRs? If patient is really serofast, follow up RPR will be low-positive again. Then, can we assume they have had sufficient treatment without having done an LP? [IA]
- Only desensitize if pregnant [MS, VA]

Syphilis Epidemiology

- Seeing more in young MSM with HIV. [CA]
- Dramatic increase in syphilis cases past 1 year [IN]
- I am now seeing more syphilis than ever. I had not seen primary syphilis since being a student and now I am again. [GA]
- I am not seeing a lot of patients in the STD clinic with primary syphilis. Is this being observed by others? [NY]
- Have seen an 1100% increase in this area over the past few years. [CA]
- See secondary syphilis several times per month in patients with HIV [DC]
- Syphilis incidence seems to be on the rise in my area (as reported in other areas of the US). [OH]

General Comments about Syphilis and this Survey

- Does anyone have comments on use of daily ceftriaxone for neurologic or ophthalmologic syphilis to allow for OPAT? [FL]
- Send us back the right answers! [GA]
- We do need to be reminded that CDC guidelines have appeared- with the pertinent changes. Maybe IDSA or CDC could send us update links. [MD]
- Everyone should read Dan Musher's recent paper (Musher DM. Neurosyphilis: diagnosis and response to treatment. CID 2008 Oct 1;47(7):900-2.) [TX]
- [This survey is an] excellent idea [WA] • Very timely! [TN] • Awaiting results. [NC] • Definitely needed [IN] • Hope you can draw a useful consensus. [WI]
- I am answering from memory but I usually consult Sanford with each STD case. [IL]
- I think there should be a "cheat sheet" on syphilis and serologies; it is confusing to ID docs. [GA]
- I feel "rusty" on this topic, but didn’t stop and reread as I would in a real clinical situation. [CO, OR]
- Many currently practicing primary care physicians have little appreciation for the evaluation or treatment of this potentially serious infection. [GA]
- Scenarios described do not cover all relevant circumstances which I have encountered. [NC]
- Who wrote these questions? They don't seem to reflect much experience with the management of syphilis. [NY]
- I have had at least one patient that we had to keep in the hospital for 21 day for Aq PCN due to the fact that he had previously failed Rocephin as an out patient, and he was HIV negative. [FL]
- Would appreciate further guidance for the issues asked about above. thanks. [VA]
- Very, Very interesting. I can see the inconsistency in my management. hmm. [NJ]
- Appreciate the survey - interested in results. This is a great way to get information about practices in areas lacking empiric data. [CA]
- Eager to hear the responses. I couldn't find any references to guide me in answering the questions about the acceptable RPR in managing neurosyphilis [OR]