CLINICAL GUIDELINE

Syphilis

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Syphilis

Contents

WHAT'S NEW:

Late latent treatment: Late doses can be given within 14 days of the previous dose and do not need to be re-started

Introduction

All patients diagnosed with Syphilis should be given a detailed explanation of their condition and this should be reinforced with the offer of written information.

Syphilis in Pregnancy
Refer to BASHH guidelines (beyond the scope of this document)

History taking and Surveillance
Currently high levels of syphilis, mainly in GBMSM but also seen in heterosexuals.

A national surveillance scheme exists for all early infectious syphilis. This uses laboratory data and clinician-initiated reports. Each clinic should be aware who completes these forms in their area. Completion of this form should be recorded in the patient clinical notes.

Clinical and laboratory assessment:

- Testing for Syphilis **always** involves blood tests. **In addition,** if there are suspicious lesions then dark ground microscopy and PCR should be performed where possible (see under primary syphilis)
- Blood tests for syphilis are either known as 'Treponemal' or 'non-treponemal' tests for syphilis:
    - Treponemal tests include TPHA, Treponemal total antibody EIA, and Inno-LIA. These should not be used to assess disease activity and remain positive for life in most patients
    - Non-treponemal tests include RPR and VDRL, and are quantitative. They are important for monitoring response to treatment and possible reinfection. West of Scotland Specialist Virology Centre use RPR.
- The initial screening test is a Treponemal total antibody EIA. If the screening test is found to be positive, further tests will be required and requested by the lab. These may include RPR, TPHA, Inno-LIA blot, and specific IgM. These are done at the West of Scotland Specialist Virology Centre at Glasgow Royal Infirmary.
- Inno-LIA blot is recommended when the confirmatory test does not confirm the positive treponemal screening test result
- All positive tests should be repeated on a second specimen for confirmation, and for baseline RPR
- If syphilis is suspected **clinically**, indicate this clearly on the request form

Examination:
- Early disease (primary/secondary/<2 years): Genital examination; skin examination including eyes, mouth, scalp, palms and soles. Neurological examination should be performed if neurological symptoms (e.g. cognitive dysfunction, motor or sensory deficits, ophthalmic or auditory symptoms, cranial nerve palsies, and symptoms or signs of meningitis or stroke).
- Late disease: If symptomatic - Skin; Musculoskeletal system; Cardiovascular system; neurological system.

- **HIV testing** should be recommended to all patients diagnosed with syphilis
- **A full STI screen** should be recommended to all patients diagnosed with syphilis. In addition, the need for Hepatitis B and HPV vaccination should be assessed
- **Recheck RPR on day 1 of treatment, allowing accurate assessment of response to treatment** (ensuring results being compared are from the same lab)

HIV infection and Syphilis
- Serological tests for syphilis in patients with both syphilis and HIV are generally reliable, although false negative tests and delayed sero-reactivity have been reported
- Syphilis serology is done routinely in HIV clinic, please check clinical portal for previous results
- HIV infected patients with early syphilis ***may*** be more likely to develop multiple/ large or deeper genital ulcers
- HIV infected patients with early syphilis ***may*** have an increased risk of neurological involvement, unusual neurological manifestations, and higher rate of treatment failure
- HIV infected patients may have neurological abnormalities that may be difficult to differentiate from neurosyphilis. Limited case review data suggests higher risk of neurosyphilis in HIV+ if RPR >=1:32. Please discuss this result with a senior GUM clinician (i.e. Consultant, Associate Specialist, Specialty Doctor, Specialist Registrar)
- A lumbar puncture is recommended in **all HIV positive patients with:**
    a) Serological treatment failure
    b) Neurological or ophthalmological signs/ symptoms
    c) Consider those with late syphilis and CD4<350
- Both treponemal and non-treponemal serologic tests behave in the same manner as in HIV-negative individuals. Unusual serologic responses, such as false negative and delayed seroreactivity have been observed in HIV-infected individuals. Please ask a senior clinician for advice in interpreting serology if you are unsure.
- Patients with neurological signs and symptoms (including ophthalmic involvement) should be investigated for neurosyphilis with CSF examination. ***(see section 6 on neurosyphilis investigation for more information)***. Pleocytosis (raised white cell count) and raised protein

levels are commonly seen in HIV-positive patients even without syphilis neurological involvement.
- HIV infected patients may also be more likely to have rapid progression to gummatous syphilis
- HIV infected patients may have a slower rate of decline of RPR after treatment
- HIV co-infected patients should be followed up for life with at least six monthly serology (consider 3-monthly in an outbreak situation depending on risk factors). Please link in with their HIV clinic.

1. Incubating Syphilis / Epidemiological treatment

If a patient is asymptomatic and reports exposure to infectious syphilis, discuss the option of:
- Immediate epidemiological treatment before any results have been received, or
- Serological surveillance repeating the serology at 6 weeks and 3 months:
  - treat if serology becomes positive
  OR
  - if serology is negative at 6 weeks and 3 months, AND there has been no further exposure, no treatment is required

In an outbreak situation epidemiologic treatment should be given especially if there is a chance the patient will not return.

Epidemiologically treated patients still require serological follow-up.

***Benzathine penicillin 2.4MU intramuscular**

For administration, see appendix 1

PENICILLIN ALLERGY: Doxycycline 100mg twice daily orally for 14 days

Note: there have been some reports of azithromycin resistance for syphilis – so it should not be used!

2. Primary Syphilis

Incubation period 21 days (9-90 days).

<u>Symptoms and Signs</u>
- **Characterised by an ulcer known as "*the chancre*", in genital and non-genital sites, with localised lymphadenopathy**
- The chancre is often painless with a clean base and indurated edges, BUT can be multiple and painful
- Depending on the site, chancres may go unnoticed and heal spontaneously

- **Any anogenital ulcer should be considered to be syphilis until proven otherwise**

Diagnosis

Dark ground microscopy, PCR testing and serology can help in the diagnosis of primary syphilis.

- Where possible/ available perform **dark ground microscopy** of the serous exudate from any visible ulcers. Clean the surface of the ulcer, squeeze to allow serous fluid out, serum on to cover slip and the onto slide, slide taken to lab **immediately**. (Please check appropriate lab staff are able to review the slide immediately, before you take the sample). Do not attempt dark ground if Mpox diagnosis is considered. ***(NB: Dark ground microscopy is of no value in intra-anal or oral lesions. Only take a dark ground if you know how, get help if you don't)***
- If dark ground microscopy is not available, then consider sending the patient to the appropriate centre
- If a suspicious lesion is dark ground negative, take a PCR test and consider bringing the patient back for up to two more dark grounds and repeat serology one week later
- **PCR testing** is available via the Regional Virus laboratory in Glasgow: place the swab in viral transport medium. PCR is the preferred method for oral and other lesions where contamination with other commensal treponemes is likely. PCR is not a replacement for dark ground microscopy due to the time taken to get the result but should be done alongside dark ground microscopy if it is available for anogenital ulcers.

Please note all PCR ulcer swabs will be tested for HSV/Syph PCR

Serological tests in primary syphilis

- May be **negative** at this stage (usually become positive 2 weeks after the chancre appears)
- If initial serology is inconclusive and there is a clinical suspicion, arrange repeat serology a week later and ideally at 6 weeks and 3 months
- Avoid the use of antibiotics, if possible, at this stage if the diagnosis remains uncertain **and the patient reports no exposure to syphilis.** Treatment at this stage may prevent a serological response. Likewise, **if the patient is requiring antibiotics for another reason, then this may affect syphilis serology**

Management

Treatment must be initiated **as soon as a diagnosis is reasonably established** to limit infectivity and risk of progression to secondary syphilis. Do not defer therapy. If you are happy with the clinical picture and the dark ground/PCR is positive.

***Benzathine penicillin G** 2.4 MU **intramuscular**
For administration see appendix 1
PENICILLIN ALLERGY: Doxycycline 100mg twice daily orally for 14 days

Complications of Treatment

1) Jarisch Herxheimer reaction may occur at approximately 8 hours. This is an acute febrile illness with headache, myalgia, rigours which resolves in 24 hours and is common in early infection (advise rest, paracetamol). Usually this is not clinically important unless there is neurological or ophthalmological involvement or if the patient is pregnant. In these situations, prednisolone and further monitoring may be advised (discuss with consultant)
2) Anaphylaxis – facilities for resuscitation must be present. Refer to local policy for further guidance
3) Brancaster brand benzathine contains excipient soya lecithin. Patients with an allergy to soya or a severe peanut allergy (i.e. anaphylaxis) are not suitable to receive this. In these patients treat as penicillin allergy i.e. with doxycycline

Patients should remain on the premises for 15 minutes after receiving their 1st injection to allow observation for immediate adverse reactions.

Partner Notification

All patients diagnosed with syphilis need specialist input, and to be seen by a sexual health adviser experienced in partner notification for Syphilis at diagnosis and at each follow up visit, until partner notification and any local surveillance is documented as complete. Sexual partners within the last 3 months should be notified.

Follow-up

- Clients should refrain from sexual contact until any lesions are fully healed and 2 weeks following treatment completion
- If clinically indicated assess at the end of treatment. Repeat serology at 3, 6 and 12 months after the end of treatment regime then if indicated, six monthly until RPR is negative or serofast
- Please refer to “syphilis positive results” flow chart for further advice on interpreting serology **(appendix 3)**
- If RPR was positive at presentation expect a four-fold drop (2 dilution steps) in titre by six to twelve months.
- If RPR titre does not fall, or at any stage shows a >2-fold rise, discuss with senior doctor. Refer to syphilis results flow chart (appendix 3)
- Discharge only at 12 months if RPR negative or if RPR is serofast and has appropriately decreased as above**, patient can be discharged earlier if RPR negative**
- Ask permission to write to GP to confirm treatment complete and SHA to action this unless complex symptoms (e.g. neurosyphilis) or pregnancy (SEE APPENDIX 4- GP LETTER)

3. Secondary Syphilis

Develops in 25% of untreated patients, typically 3 months after infection acquired.

Symptoms and Signs

- **Multi-system involvement within the first 2 years of infection**
- Often associated with a generalised rash affecting palms and soles, muco-cutaneous lesions, condylomata lata (confluent wart like lesions) and generalised lymphadenopathy and fever.
- Less commonly: patchy alopecia, anterior uveitis, meningitis, cranial nerve palsies, hepatitis, splenomegaly, periosteitis, arthritis and glomerulonephritis.

Diagnosis

Dark-ground microscopy and PCR: from mucous patches or condylomata lata

Serological tests: invariably all positive.

Other tests: Full blood count, liver and renal function tests are rarely required

Rapid tests: Point of care fingerprick tests may be useful if no previous history of syphilis, and a rapid result is required (especially useful for confirming clinical suspicion of secondary syphilis). Discuss with Senior Doctor and see pack for instructions on how to use. They are insufficiently sensitive to exclude syphilis completely and should not replace formal serological testing.

Treatment, Complications & Follow-up

As for primary syphilis, **unless** the patient is pregnant or has neurological/ ophthalmological signs/ symptoms.

For those with neurological/ophthalmological symptoms and signs (and those who are pregnant) discuss management with senior GUM clinician (i.e. Consultant, Associate Specialist, Specialty Doctor, Specialist Registrar), **and** the relevant speciality as imaging, lumbar puncture, pre-treatment steroids and admission for antibiotic treatment may be recommended.

SEE section 6 on neurosyphilis & appendix 2 for referral details.

DO NOT defer therapy if a single blood test is positive and the clinical picture fits: start treatment and take a confirmatory blood test.

Partner notification

Partner notification may need to extend to 2 years.

4. Early Latent Syphilis

Syphilis serology is positive, person is asymptomatic and is within the first 2 years of infection.

Diagnosis

1. Serological tests are positive (on two separate occasions)
   AND
2. Known to have been syphilis serology negative within the last two years **OR** has positive specific IgM with likelihood of infection in the last two years
   AND
3. Patient is asymptomatic, with no clinical evidence of disease

Treatment, Complications & Follow-up

As for primary syphilis.

Partner notification

Partner notification may need to extend to 2 years.

1. Late Latent Syphilis

Syphilis serology is positive, patient is asymptomatic and has no known negative serology within the last 2 years. See below for investigations required.

Examination

- If the patient does not have any symptoms then examination is not indicated.
- Patients who have symptoms and signs of cardiovascular involvement should have a full cardiovascular assessment. Consider an echocardiogram +/- chest x-ray before starting therapy to exclude aortic valve disease. Patients with clinical or radiological evidence of aortic valve disease must be referred to a cardiologist for further assessment
- Patients should have a thorough neurological examination if they have symptoms suggestive of neurological involvement (cognitive dysfunction, motor or sensory deficits, ophthalmic or auditory symptoms, cranial nerve palsies, and symptoms or signs of meningitis or stroke)
- CSF examination (Lumbar puncture)- there is no indication of any benefit from routine CSF examination unless:
  - there is a clinically evident neurological problem (symptoms above).
  - OR
  - Treatment failure e.g. consider if RPR not fallen 4 fold in 12 months

Please see appendix 2 "neurological investigations" for more information on how to refer for lumbar puncture

Treatment – LATE LATENT SYPHILIS

There is much less urgency in treating late syphilis and it is better to plan treatment so that it can be reliably completed

****Benzathine penicillin G** 2.4 MU intramuscular on day **1** & **8** & **15** *******
For administration, see Appendix 1
OR
****Procaine penicillin** 600,000units intramuscular
once daily for **14** days
***unlicensed medications, named patient form may be needed*
**** Late doses can be given within 14 days of the previous dose*

PENICILLIN ALLERGIC (or declines parenteral):
Doxycycline 100mg twice daily orally for 28 days

Complications

- Jarisch Herxheimer reaction is less common than in early syphilis
- Procaine reaction. This is caused by inadvertent IV injection of procaine penicillin which is minimised by the aspiration technique of injection. Lasts for less than 20 minutes and is characterised by feelings of impending death +/- seizures. Anaphylaxis should be excluded and the patient should be reassured and calmed. Sedation may be required for seizures

- Anaphylaxis – facilities for resuscitation must be present. Refer to local policy for further guidance

Patients should remain on the premises for 15 minutes after receiving their 1st injection to allow observation for immediate adverse reactions.

Partner Notification LATE LATENT SYPHILIS

- All patients to see sexual health adviser

Follow-up

- **SC SHA Telephone Follow Up** 2 weeks after end of treatment regime - to check compliance and partner notification
- 3 months - to repeat serology ± HIV test
- RPR is often negative in late syphilis, but this does not exclude the need for treatment. Follow up is to ensure adherence and for completion of partner notification. Discharge at 3 months if RPR remains negative.
- If RPR titre was raised prior to treatment, repeat at 3,6,12 months until RPR negative or reduced and serologically stable on two occasions
- Ask permission to write to the patient's GP to confirm treatment complete and give patient a written summary of treatment and discharge serology

2. Neurosyphilis

Can be early (secondary) or late (tertiary) in the course of disease.

The management and investigation of neurosyphilis should be made with a Consultant in Genitourinary Medicine/ Infectious Diseases.

Meningovascular: may be associated with early or late syphilis.

Parenchymatous: General paresis and/or tabes dorsalis.

Patients should have a thorough neurological examination to rule out focal neurology or papilloedema that may indicate raised intracranial pressure and relevant radiological imaging of the head requested if these signs are present **prior** to lumbar puncture. Neurological imaging must be considered if there are neurological signs or symptoms.

Please see appendix 2 – "Neurological investigations" for further information on how to refer for inpatient investigation.

LUMBAR PUNCTURE

In order for CSF tests to be interpreted correctly the CSF should not be macroscopically contaminated with blood. CSF tests should include:

1) Cell count
2) Total protein
3) A treponemal test
4) A non-treponemal test (RPR)

TREATMENT FOR NEUROSYPHILIS

Prednisolone 40mg orally once daily for three days, starting anti-treponemal treatment 24 hours **after** commencing prednisolone.
For ENT or optic atrophy complicating syphilis infection, a longer prednisolone course may be needed. Refer for ENT/Ophthalmology Consultant opinion. See appendix 2 for referral details.

Procaine penicillin 2.4MU intramuscular once daily for **14** days

(Unlicensed medication, named patient form may be needed)

PLUS

Probenecid 500 mg 4 times daily orally for 14 days

OR

Benzylpenicillin 10.8g-14.4g daily given as 1.8g-2.4g intravenously every 4-6hours for **14** days

PENICILLIN ALLERGIC (or declines parenteral): Doxycycline 200mg twice daily orally for 28 days

In tertiary neurosyphilis partner notification and follow-up as for late latent syphilis.

Positive CSF:
If CSF in keeping with neurosyphilis repeat LP may be required at 6 months post treatment, please discuss with senior GUM clinician for advice.

3. Tertiary syphilis: Cardiovascular Syphilis

Asymptomatic: diagnosed on clinical, radiological and echocardiographic changes.
Symptomatic: usually from aortic valve disease, aneurysmal changes of the aorta or coronary ostial occlusion.
Requires Cardiologist assessment pre-treatment. Discuss with senior doctor before referring.

TREATMENT FOR CARDIOVASCULAR SYPHILIS

Prednisolone 40-60mg orally once daily for 3 days (start 24 hours before anti-treponemal treatment)

Benzathine penicillin G 2.4 MU intramuscular on day **1** & **8** & **15**
for administration, see Appendix 1

OR

****Procaine penicillin** 600,000units intramuscular
once daily for **14** days

*(**unlicensed medications, named patient form may be needed)*

PENICILLIN ALLERGIC (or declines parenteral):

Doxycycline 100mg twice daily orally for 28 days

Partner notification & follow-up as for late latent syphilis but will also need long-term follow up with cardiology. Cardiovascular lesions may progress despite adequate treatment for syphilis.

8. Tertiary syphilis: Gummatous Syphilis

Gummatta can occur anywhere but most often affecting skin and bones. Gummatta should be managed alongside the appropriate specialist.

References

BASHH UK National Guidelines on the Management of Syphilis 2015 (updated June 2019) accessed via www.bashh.org/guidelines [Accessed December 2023]

BASHH UK guidelines for the management of syphilis 2024 accessed via https://www.bashh.org/_userfiles/pages/files/syphilis_2024.pdf [Accessed June 2025]

2020 European guideline on the management of Syphilis. Accessed via 2020-Syphilis-guideline.pdf [Accessed June 2025]

Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2021. Syphilis.www.cdc.gov/std/treatment-guidelines/syphilis.htm [Accessed June 2025]

Appendix 1: Preparation Instructions for Benzathine Penicillin 2.4MU

To reduce the pain experienced by patients receiving Benzathine and procaine penicillin injections, 1% lidocaine (lignocaine) can be used as an alternative diluent to water for injections (unlicensed indication).

Benzathine Penicillin:

- **Dose**: 2.4 Mega units IM weekly for up to 3 weeks.
- **Presentation**: Powder for suspension for injection.
- **Contra-indications**: Allergy to penicillin or lignocaine. Concomitant anticoagulant therapy. Bleeding diathesis (e.g. Haemophilia).
- **Precautions**: For patients with penicillin allergy, cross reactivity to other beta-lactams such as cephalosporins should be taken into account.
- **Reconstitute** the vial with 6-8ml (depending on manufacture brand available - see product insert) of 1% lidocaine hydrochloride BP solution. Split the resultant suspension into two equal volumes. The suspension should be administered by deep intramuscular injection in two different sites. Solutions in lidocaine MUST NOT be administered intravenously.

Administration:

1. Add solvent to vial and turn the vial gently whilst warming it in your hands
2. Extract the suspension with a needle different from the one you will use for injection.
3. To inject, stick an ‘empty’ 0.9 calibre needle into the patient.
4. Place the syringe and aspirate to check that no blood comes out.
5. Inject.

Procaine:

- **Dose**: 1.8–2.4 mega units IM daily for 14 days.
- **Presentation**: Powder for suspension for injection.
- **Contraindications**: Allergy to penicillin or lignocaine. Concomitant anticoagulant therapy. Bleeding diathesis (e.g. Haemophilia).
- **Precautions**: For patients with penicillin allergy, cross reactivity to other beta-lactams such as cephalosporins should be taken into account
- **Reconstitute** two 1.2 mega unit vials with 4 ml of 1% lidocaine hydrochloride BP solution each. The required volume should be administered by deep intramuscular injection into two different sites. Solutions in lidocaine MUST NOT be administered intravenously.

Inadvertent intravenous administration of lidocaine can cause bradycardia (which may lead to cardiac arrest), fitting and/or sedation. Use the ‘aspiration technique’ of injection to minimise the risk of this happening.

Appendix 2 - Managing Syphilis Follow up

Treatment of Primary/ Secondary/ Early Latent Syphilis in Urgent Care clinic

Clinician should:

- keep result as untreated on NaSH
- complete PHS form and hand in to SHA office
- Add to SC SHA Syphilis Telephone in 2 weeks

At 2 week follow up SHA will:

- call to confirm treatment compliance and complete PN
- confirm PHS form completed
- Add STISS coding

SHA Office:

PHS form sent to phs.bbvstireporting@phs.scot

Patient to be added to SC Syphilis Follow Up for automated texts for repeat test at 3, 6 & 12 months and SC SHA Virtual Diary at 13 month as failsafe

Treatment of Late Latent Syphilis in Urgent Care clinic

Clinician should:

- keep result as untreated on NaSH
- Add to SC SHA Syphilis Telephone 2 weeks after last injection
- If treated as precaution when there is possible infectious syphilis – note stage in notes and follow "early" flow chart

PN should be followed up during appointments for 2nd and 3rd injections

At 2 week follow up SHA will:

- call to confirm treatment compliance and complete PN
- confirm PHS form completed if relevant
- Add STISS coding
- Add to SC SHA Virtual Diary at 3 months for repeat test
- If pregnant, add to SC GUM Results for consultant letter to Obstetrician

If RPR Detectable at 3 month follow up test add to SC Syphilis Follow Up for automated texts for repeat test at 3, 6 & 12 months and SC SHA Virtual Diary at 13 month as failsafe

Treatment as a contact of Syphilis

Clinician to add patient to SC SHA Syphilis Telephone in 2 weeks

Negative

SHA to call client and check compliance.

Add to SC SHA Virtual Diary for repeat test at 3 months

Positive

Manage as per early syphilis

Appendix 3: Complications of Syphilis infection – referring to other specialties

As most patients will be seen at Sandyford Central, referral is to Gartnavel General Hospital but please note below ophthalmology arrangements for those who reside out-with GGC.

Ear, Nose and Throat (ENT)

Audiometry

Audiology can be obtained at Gartnavel General Hospital, Ground floor, outpatients by calling 0141 211 3054. They will perform audiology and return the patient with the report, there can be a wait for this, discuss with Dr of the Day if felt treatment needed urgently. The results do not come with clinical opinion discuss with ENT if any concerns

ENT opinion – this should be sought by paging the on call registrar via switchboard (0141 211 3000) or if non-urgent via SCI gateway referral to ENT consultant

Audiology

Gartnavel - 0141 211 3054

QEUH - 0141 452 3152

RAH - 0141 314 6860

Ophthalmology

For patients requiring an appointment within 24-48 hours, appointments can be arranged at the Ophthalmology Acute Referral Centre (ARC) - opening hours: Mon - Sat 0900 -1630 - in Ophthalmology department, Gartnavel General Hospital by phoning 0141 301 7847 (phone number for referrer use only).

For emergency advice and immediate appointments, phone the nurse triage line on 07534230405 or 07534228544 (phone numbers for referrer use only).

Attendance is by appointment only with referral letter so ensure patient is given written referral letter and appointment time before they leave Sandyford services.

ARC will only cater for patients within City of Glasgow Hospital catchment areas. Please see staff net under 'ophthalmology' for arrangements for Clyde (RAH, IRH), Lanarkshire, Ayrshire and Forth Valley.

Neurosyphilis

Useful numbers

Ophthalmology Level 1 Gartnavel

0141 211 1033 / 0141 211 1030

QEUH

0141 452 3163

eyeopd@ggc.scot.nhs.uk

RAH

0141 314 7020 / 0141 887 9111

ID 5C QEUH

82471 / 0141 201 1100 pager 15295

Neurological investigations

If there is a suspicion of neurosyphilis, a ward admission to QEUH 5C (Infectious Diseases) for a CT and LP can be arranged by contacting ID registrar on 82471 or page 15295 (via QEUH switchboard – 0141 201 1100).

Please fill out an outpatient medical note (Infectious Diseases e-form or Infectious Diseases patient note) on Clinical Portal detailing: presenting complaint/symptoms; any positive finding on examination; details of investigations performed; and proposed plan for further investigation and treatment. If patient has a penicillin allergy, then please advise an alternative regime to be administered.

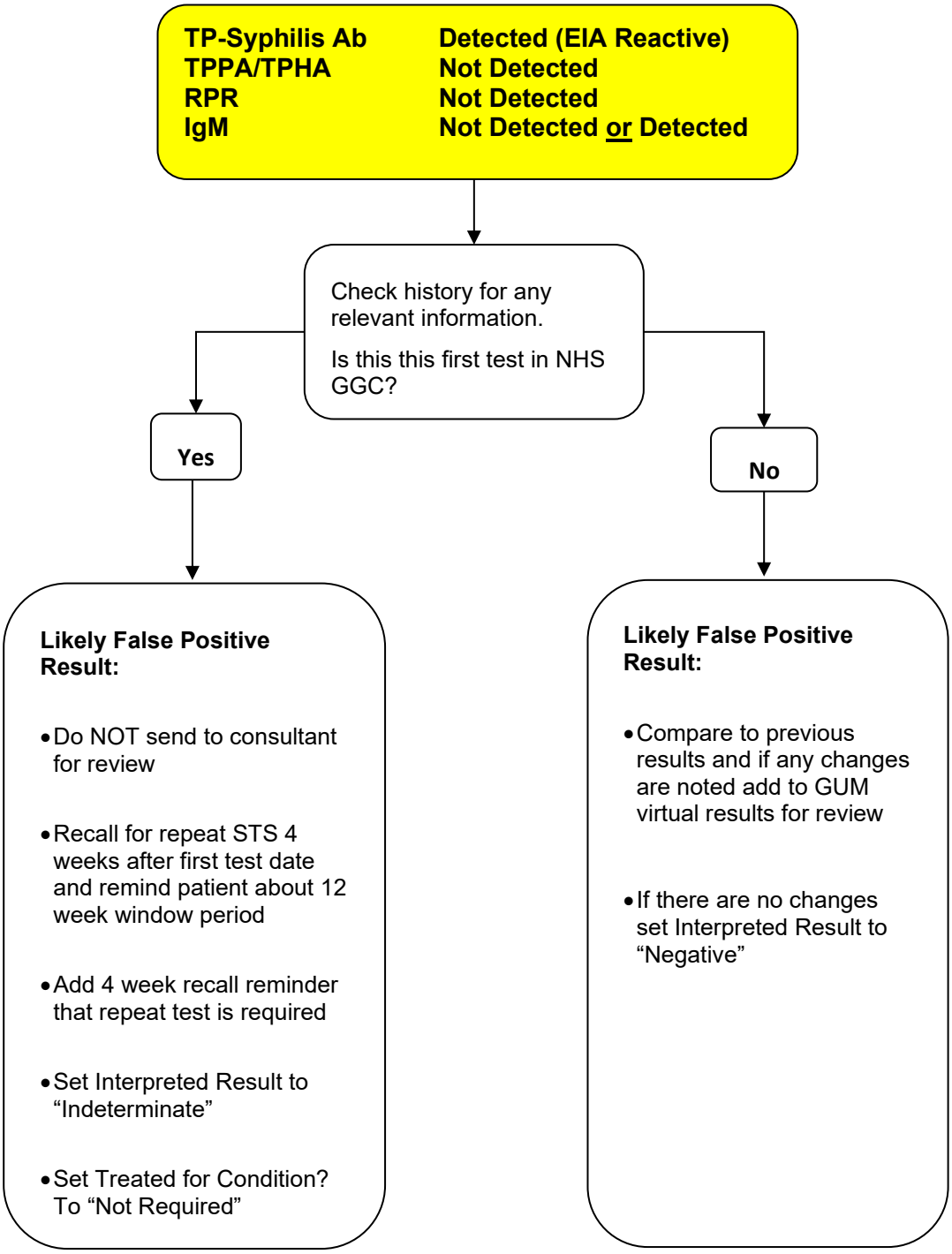
On discharge from 5C, the ID team will provide the patient with remaining prednisolone and probenecid; and remaining parenteral antibiotic therapy will be administered at OPAT (Outpatient Parenteral Antibiotic Therapy) department at QEUH unless otherwise arranged.

Follow up serology and Partner Notification will continue to be arranged via the SHA team.

Appendix 4: Syphilis – Presumed False Positive Results

NB – Please see separate management pathway for results from any antenatal testing.

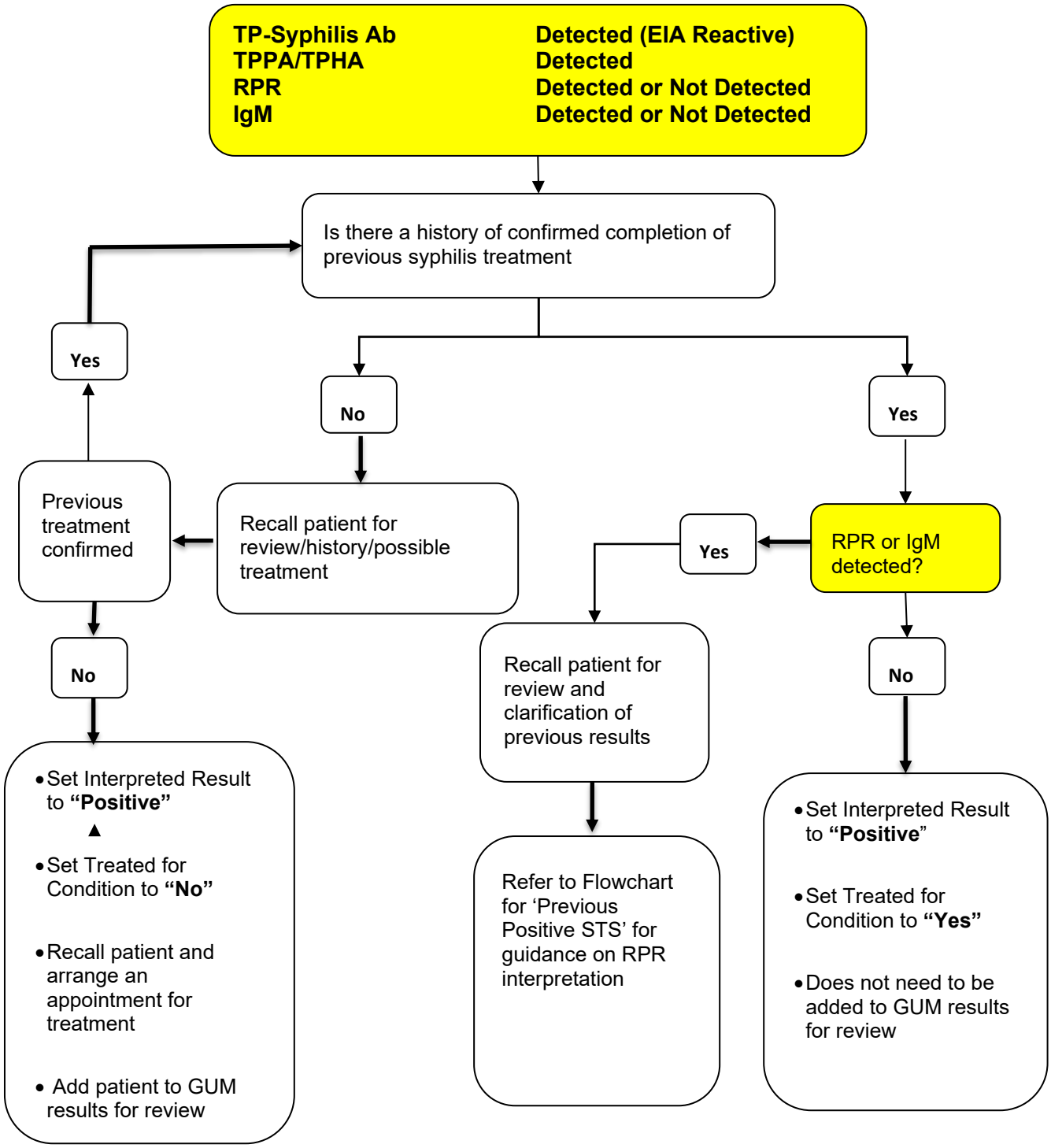
Remember to use 'Results Reporting' or Patient Summary to see all available syphilis markers



Syphilis – New Positive Results

Where no previous Syphilis Test can be confirmed **or** last recorded Syphilis Test is Negative

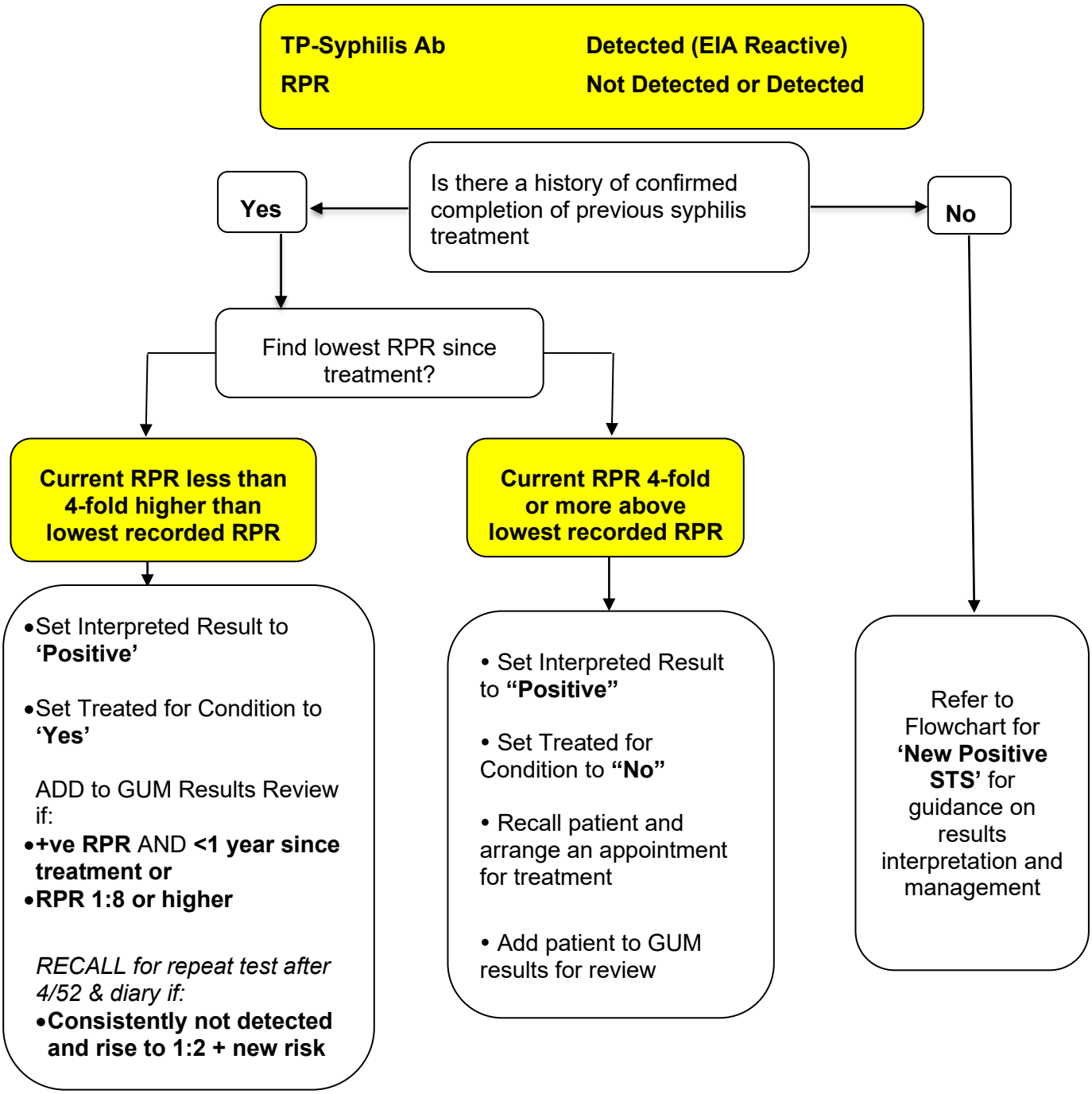
NB – Remember review full results in 'Results Reporting' area.



Syphilis - Positive Results

Previous Positive STS

NB – Remember to use 'Patient Summary' or 'Results Reporting' to see all syphilis markers.



Appendix 5: GP Letter - Confirmation of Syphilis Treatment

These sections will be pre-populated

Complete these sections

Date:

GP Details:

To Whom It May Concern

Patient Name:

CHI:

This patient was tested at Sandyford Sexual Health Services on …… and was diagnosed with Primary/Secondary/Early Latent/Late Latent (delete accordingly) syphilis.

Treatment was as follows:

Date(s): ……. Treatment: …….

The patient has attended for all follow up bloods and, where possible, the Partner Notification process has been completed. No further follow-up for syphilis is planned.

Serological Results	Initial	Final
Date		
RPR		
TPHPA		
IgM		
EIA		
INNO LIA		

Comments: Add any relevant comments if required

For further information please contact the Sexual Health Advisers at

ggc.sandyfordsexualhealthadvisers@nhs.scot

{Insert name}

{Insert Job Title}

Appendix 6: Antenatal Syphilis Management

Lab report EIA positive antenatal sample to Sandyford Shared Care team

Result to 'GUM cons results' list for interpretation and documentation of plan on NaSH.

GUM cons to add to antenatal syphilis worklist on clinical portal

SHA team to action plan as follows:

Result consistent with false positive EIA

Inform obstetric team and advise repeat serology ASAP

Result consistent with active infectious syphilis

Inform obstetric team

Recall women to Sandyford for repeat serology and GUM consultation

Result consistent with previously treated or late latent syphilis

If previous treatment not confirmed

Inform obstetric team

Recall women to Sandyford for repeat serology and GUM consultation

If previous treatment and unchanged serology confirmed:

Document on clinical portal.

Letter to GP, Obstetrician/Midwife and neonatal team (use template on NaSH)

GUM cons to document in Obstetric record.

GUM team manage syphilis infection as per protocol.

Letter to GP, Obstetrician/Midwife and neonatal team (use template on NaSH).

Discuss at BBV/Obs MDT with documentation of plan in obstetric notes

When treatment complete:

GUM consultant to discuss at BBV/Obs MDT and document treatment completion and neonatal management plan (as per protocol) in obstetric notes. Neonatal team to be informed as outcome from MDT.

Neonatal Syphilis blood results

The failsafe team are automatically copied in on these results. The baby will have a NaSH record and results documented, and they will be put on the 'SC GU results' tab on NaSH for senior GUM clinician review and comment, alongside mum's NaSH record for review.

Appendix 7: Letter to GP, Obstetrics & Neonatal team re: Antenatal Syphilis Diagnosis & Management

- And to be uploaded to mum & baby's Badgernet and clinical portal records

Name: _____ **CHI:** _____ **Date:** _____

Date of syphilis diagnosis: _____ Pregnancy EDD: _____

Stage of syphilis diagnosed in pregnancy _____

Additional Information _____

HIV and other BBV status _____

Treatment details _____

Date treatment completed/due to complete _____

Syphilis serology results and date	
EIA	
TPHA	
IgM	
RPR	

*Please note further serological follow up will be completed by Sandyford

GUM ADVICE TO PAEDIATRICIANS (tick as required)

- **see West of Scotland congenital syphilis guideline**

Infant requires no physical examination above routine. No syphilis serology required	
Assess infant clinically: if no physical signs of syphilis, perform syphilis serology on infant serum (not cord blood) for EIA IgM and RPR. ***N.B. If physical signs are present consider additional investigations. Refer to West of Scotland Syphilis guideline and discuss with GUM ore ID consultant***	
Treat infant at birth with _____ after clinical assessment, perform syphilis serology on infant serum (not cord blood) for EIA IgM and RPR and additional tests as per guideline	

Please discuss infant blood test results with GUM (or Paediatric infectious diseases team if OOH or suspicion of neonatal infection)

Follow Up

Infants who have serology tests at birth require follow up as per the three pathways detailed in the WoS guideline. Tick the appropriate follow-up pathway below once the infant's serology is known.

Baby Name _____ CHI _____

Age	**Infants treated for congenital syphilis at birth**	**Infant not treated for syphilis and RPR <4x mother's and IgM negative at birth**	**Infant not treated for syphilis and RPR and IgM negative at birth**
Select Follow up pathway	☐	☐	☐
1 month	RPR TP Syphilis IgM		
3 months	RPR TP Syphilis IgM	RPR TP Syphilis IgM	RPR TP Syphilis IgM **If negative: discharge** **If positive: Repeat at 6 months**
6 months	RPR	RPR **If negative: discharge** **If positive: repeat at 12 months**	RPR **If negative: discharge** **If positive: discuss with GUM team.**
12 months	RPR **Discharge if RPR has achieved sustained 4x drop from peak level.** **If RPR remains higher, discuss with GUM team.**	RPR **If negative: discharge** **If positive: discuss with GUM team.**	

For further information please contact Sandyford on 0141 211 8634.

Yours sincerely,

Signature: _____ Consultant in Genitourinary Medicine

Signature: _____ Consultant Neonatologist