

SYPHILIS

Case definition

The syphilis case definitions, excluding congenital, can be found in the Nova Scotia Surveillance Guidelines here:

<https://novascotia.ca/dhw/populationhealth/surveillanceguidelines/non-congenital-syphilis>.

The congenital syphilis case definition can be found in the Nova Scotia Surveillance Guidelines here: <https://novascotia.ca/dhw/populationhealth/surveillanceguidelines/congenital-syphilis.pdf>

Outbreak definition

Syphilis outbreak case definitions can be found within the Nova Scotia Surveillance Guidelines (links above).

Public Health Significance

Syphilis is of significant public health importance in Canada. There has been a steady increase in rates since 2014. Gay, bisexual and other men who have sex with men (gbMSM) have historically been disproportionately affected by syphilis. Since 2018 there has been an increase in reported cases among female populations which has resulted in a re-emergence of congenital syphilis. Intersections of social determinants of health including housing instability, mental health and addictions, stigma, discrimination, violence, and lack of access to culturally appropriate health care have led to inequitable occurrence of syphilis in vulnerable populations. When left untreated, syphilis may cause serious and devastating health problems. As such, it is imperative to work within the context of an individual's or a community's lived experience and build on strengths.

Congenital syphilis can result in stillbirth and early pregnancy loss, as well as substantial morbidity in newborn infants. If congenital syphilis goes unidentified and untreated, infants can go on to develop late-stage manifestations of congenital syphilis, however, this is a rare occurrence in developed countries.

In Canada, the increasing rates of congenital syphilis have highlighted gaps in community resources needed to prevent the spread of syphilis. Congenital syphilis can be prevented through identification and treatment of syphilis before or during pregnancy.

In Nova Scotia, the public health objectives of case and contact management are to:

- reduce ongoing disease transmission through prompt identification and follow up of cases and contacts to minimize mortality, morbidity and prevent congenital syphilis.
- support linking individuals to treatment and wrap around supports to decrease risk

of future sexually transmitted and blood borne infections (STBBI).

Causative agent

Treponema pallidum (*T. pallidum*), a bacterium of the order spirochaeta. Non-sexually acquired treponemal infections due to other sub species or species of *Treponema* cause pinta, yaws, and bejel.

Source

Humans.

Incubation

See [Table 1](#) below referencing incubation period.

Transmission

Direct contact with primary or secondary lesions on the skin or mucous membranes of an infected person. These lesions contain infectious spirochetes.

Transmission occurs primarily during sexual contact (inclusive of vaginal, anal, oral sexual contact, and sharing sex toys). Kissing, sharing of needles and injection equipment, blood transfusion (in Canada, all donated blood is screened for syphilis), accidental inoculation (i.e. needle stick injury) and solid organ transplantation have rarely been reported as routes of transmission.

Transplacental transmission during pregnancy can occur as early as nine weeks gestation. Most infants with congenital syphilis are infected in utero, but they can also be infected by contact with an active genital lesion at the time of delivery. Syphilis is not transmitted via breastmilk; however, transmission may occur if there is direct contact with an infectious lesion present on the breast. Lesions present on a neonate are considered infectious.

Communicability

An infected individual is considered communicable during the primary, secondary and early latent stages of the disease.

The risk of transplacental transmission from an untreated pregnant person to fetus is 70-100% with primary or secondary syphilis, 40% with early latent syphilis and 10% in late latent stages.

Symptoms

Syphilis is classified into **stages** that reflect progression of the disease if left untreated and the degree of infectivity.

TABLE 1: SYPHILIS STAGING

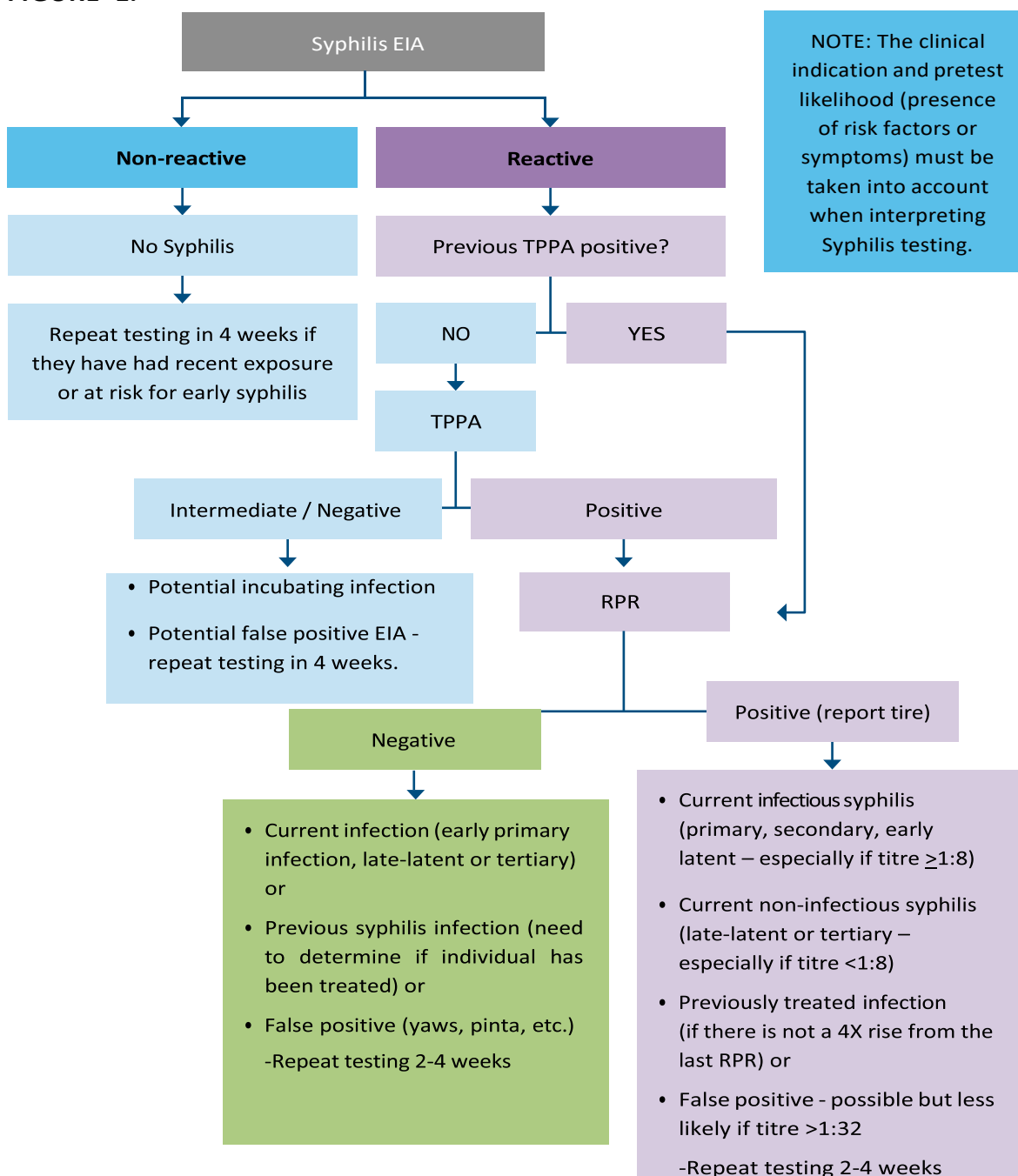
Stage	Infectivity	Incubation period (range)	Clinical manifestations
Primary	Infectious syphilis (70% vertical transmission rate)	3 weeks (3 days to 90 days)	Painless lesion (chancre) at the site of inoculation. Regional lymphadenopathy may occur.
Secondary	Infectious syphilis (70% vertical transmission rate)	2 weeks to 12 weeks (2 weeks to 6 months)	Typically starts with rash. May also include fever, malaise, lymphadenopathy, mucous lesions, condyloma lata, patchy or diffuse alopecia, meningitis (e.g. headaches), uveitis/retinitis (e.g. blurred vision, eye redness, flashes or floaters) or otic symptoms (e.g. hearing loss).
Early Latent	Infectious syphilis (40% vertical transmission rate)	<1 year	Asymptomatic. 25% probability of relapse to secondary syphilis if untreated.
Late Latent	Non-infectious syphilis, except during pregnancy where there is a 10% vertical transmission rate.	≥1 year	Asymptomatic.
Tertiary (excluding neurosyphilis)	Non-infectious syphilis	10 - 20 years 1-46 years (most cases 15 years)	Cardiovascular: Aortic aneurysm, aortic regurgitation, coronary artery ostial stenosis Gumma: Tissue destruction of any organ; manifestations depend on the site involved.

Neurosyphilis	<p><1 year since infection: Infectious</p> <p>>1 year since infection: Non-infectious</p>	<2years - 20 years	<p>May be asymptomatic or present with ataxia, vertigo, dementia, headaches, personality changes, Argyll Robertson pupil, otic symptoms (e.g. hearing loss) or ocular symptoms (e.g. blurred vision).</p> <p>Co-infection with HIV may result in more rapid progression to neurosyphilis with more aggressive and atypical manifestations.</p>
Congenital—Early	Infectious syphilis (if lesions present)	Onset < 2 years	<p>Clinical manifestations may include anemia, neurosyphilis, rhinitis, osteochondritis, hepatosplenomegaly, mucocutaneous lesions, or fulminant disseminated infection.</p> <p>50% to 90% of infants are asymptomatic at birth and symptoms do not present for weeks to months.</p>
Congenital—Late	Noninfectious syphilis	Onset > 2 years after birth	<p>May include anemia, neurosyphilis, bone involvement, interstitial keratitis, lymphadenopathy, hepatosplenomegaly, dental abnormalities (Hutchinson’s teeth).</p>
Syphilitic Stillbirth	Infectious syphilis (if lesions present)	Unknown	<p>A fetal death after 20 weeks' gestation or in which the fetal weight is greater than 500 g.</p>

Diagnostic testing

In Nova Scotia the “reverse algorithm” is used where an individual’s serum is first tested with a treponemal specific enzyme immunoassay (EIA) that detects IgM and IgG to *T. pallidum* and reactive specimens are subsequently tested with *T. pallidum* Particle Agglutination (TPPA), a treponemal test, and a Rapid Plasma Reagin (RPR), a non-treponemal test (NTT) (Figure 1). See Table 2 for Interpretation of serology and Table 4 for following quantitative RPR results over time to monitor response to treatment.

FIGURE 1:



The interpretation of syphilis serology should be made in conjunction with someone experienced in this area (i.e. microbiologist, infectious disease physician). Every attempt should be made to obtain and document the prior history of treatment for syphilis and prior serologic results in order to avoid unnecessary retreatment.

TABLE 2: INTERPRETATION OF SYPHILIS SEROLOGY

EIA result	TPPA	RPR	Interpretation
Negative	Not done	Not done	No evidence of syphilis. Repeat serology if at risk for early syphilis (window period is approximately 3 to 4 weeks).
Reactive	Negative	Negative	May represent a false positive EIA result or early seroconversion. Repeat testing in 4 weeks. If unchanged represents false positive EIA.
Reactive	Reactive	Non-reactive	Current or previously treated syphilis OR Yaws, pinta, bejel in patients from an endemic country Repeat testing in 2 weeks.
Reactive	Reactive	Reactive (dilutions may vary)	Current or previously treated syphilis OR Yaws, pinta, bejel in patients from an endemic country Repeat testing in 2-4 weeks.

IMPORTANT CAVEATS FOR SEROLOGIC DIAGNOSIS:

Serology may be falsely negative in early syphilis. As outlined in [Figure 1](#), serology can be falsely negative in the first 4 weeks of infection. If there is a high index of suspicion, then the tests should be repeated in 2 to 4 weeks.

Diagnosis of Re-Infection: The EIA and TPPA will remain positive for life in previously infected individuals. If the RPR increases 4-fold (i.e. two dilutions 1:8 to 1:32) this would indicate serologic evidence of reinfection.

Individuals from areas where there are other treponemal diseases (Pinta, Yaws, Bejel) may have false positive EIA/TPPA. It would be reasonable to seek expert advice if an individual from these regions presents with a positive test.

Individuals may remain serofast. Although the reactivity to the RPR will disappear in the majority of people who are successfully treated with benzathine penicillin, a small

majority will have a persistent low titre (e.g.1:8).

Congenital Syphilis Testing and Diagnosis:

Diagnosis of congenital syphilis can be difficult as antibodies transferred from the birth parent complicate interpretation of serological results. Additionally, it can be challenging to differentiate congenital from acquired syphilis in children. As such, congenital syphilis diagnostics are overseen by pediatric infectious disease specialists.

Infants Born to a Birth Parent with Reactive Syphilis Serology:

- Follow up serology is recommended for **all** infants whose birth parent had reactive syphilis serology.
- Infants with reactive NTT at delivery should have serology repeated every 2 to 3 months until 6 months of age (regardless of if treated or not).
- The course of serological follow up should be overseen by pediatric infectious disease specialists. For more information on serological monitoring of congenital syphilis, refer to the Canadian Paediatric Society - [Diagnosis and management of congenital syphilis – Avoiding missed opportunities](#).

Screening Tests

Rapid point of care testing for syphilis may be available in community settings, currently as dual syphilis/HIV point of care tests (POCTs). Accuracy will vary based on test used. These treponemal tests are considered screening tests and like other treponemal specific tests, the POCT will remain positive for life so have little value in people with known prior infection. Confirmation through laboratory testing is indicated and further linkage to care and treatment is of utmost importance.

In some circumstances Dried Blood Spot (DBS) testing may also be used in community settings. DBS is a method of blood collection that uses a single drop of blood on filter paper and is tested with treponemal specific EIA. DBS has advantages in its ability to reduce barriers to testing given that collection can occur at community sites. However, positive results require confirmatory serological testing using the reverse algorithm.

Treatment

Long-acting (LA) benzathine penicillin G is the preferred treatment for most cases of syphilis. Treatment is under the direction of the attending health care provider and is out of scope for Public Health.

Treatment of neurosyphilis cases should be done in consultation with infectious disease specialists.

Treatment during pregnancy should be done in consultation with obstetrical/fetal specialists and infectious disease specialists. Treatment of infants with congenital syphilis should be done in consultation with pediatric infectious diseases specialists.

For further information about the treatment of syphilis see:

- Canadian Guidelines on Sexually Transmitted Infections - [Syphilis Guide: Treatment and Follow Up](#)
- Canadian Paediatric Society - [Diagnosis and management of congenital syphilis – Avoiding missed opportunities](#) for treatment of congenital syphilis, neonates exposed to syphilis, and syphilis in pregnancy.

Post- treatment monitoring of serologic tests, adequate serologic response, and other follow up are outlined in [Table 3](#) under Public Health Case Management and Response.

PUBLIC HEALTH MANAGEMENT & RESPONSE

Case management

Upon receiving a report of syphilis public health should confirm diagnosis and staging by communicating with the primary care provider. Not all primary care providers are familiar with interpretation of syphilis serology. In this case, the primary care provider should seek input from a provider more experienced in this area. It may also be helpful to explain the role of Public Health in syphilis case and contact management to the primary care provider.

Initial information that should be collected from and discussed with the **primary care provider** includes:

- Prior history of treatment for syphilis and prior serologic results:
 - Every attempt should be made to obtain this prior history to avoid unnecessary retreatment.
- Reason for testing
- Symptoms
- Staging of syphilis:
 - Review serology in conjunction with information collected from the clinician. Staging may be adapted as needed if additional information is later shared by the case.
 - [Additional information syphilis staging Public Health Agency of Canada](#)
 - If the Public Health case definition is different from the clinical staging definition, which is occasionally seen with early latent/late latent disease, then the Public Health case definition should be used to inform the trace-back period for contact tracing. Clinical staging should be used to inform treatment and serological monitoring and follow up. The public health case definition should be used for case classification purposes.
- Risk factors.
- Any known Pregnant contacts.

- Appropriate treatment initiated. Note: Review with primary care provider, the importance of case compliance with treatment and ongoing [Public Health Follow-Up](#).
 - Ensure provider is aware of risk of possible [Jarisch-Herxheimer reaction](#) to treatment with penicillin. This reaction is more common in secondary syphilis (70% to 90%) but can occur at any stage of infection and is usually not clinically significant unless there is neurologic or ophthalmic involvement, or in pregnancy as it may cause fetal distress and premature labour.
- Clinical plan of care; refer primary care provider to the [Canadian Guidelines on Sexually Transmitted Infections \(STI\)](#), so they are aware of their role in ongoing monitoring of serologic tests and other follow-up for syphilis.
- Referral to infectious disease specialists is strongly recommended for syphilis cases who are living with HIV, have symptoms with neurological involvement, during pregnancy and cases of congenital syphilis. If pregnant then obstetrics should also be consulted.
- Testing results for other sexually transmitted and blood born infections (STBBI), particularly HIV as co-infection may change the clinical presentation and/or progression of syphilis, as well as increased risk of early CNS disease. If this testing has not been done, then the provider should be advised accordingly.

Once preliminary information is obtained, **interview the case:**

- It is important to build trust and rapport so that the case feels safe in disclosing sensitive details regarding sexual history, partners, and possible pregnancy.
- Discuss Public Health’s role regarding case management, contact tracing and confidentiality, and preventing or controlling further spread.
- Gather information needed for contact tracing, including pregnant contacts (see below, “contact tracing” section for details).
- Obtain any additional details about current and past symptoms and risk factors, as well as prior history of syphilis and treatment information, if applicable.
- Provide education and refer the case to community support and resources as appropriate (i.e. local STI clinics, harm reduction and addiction services, AIDS Coalition of Nova Scotia, pride Health, etc.).

Additional considerations for syphilis during pregnancy and/or congenital syphilis cases

- Building trust, rapport, and addressing barriers to adequate prenatal care is crucial for diagnosing and treating cases of syphilis during pregnancy and preventing congenital syphilis.
- Fear of child apprehension can be a major barrier to accessing care among pregnant people who use drugs and/or who are Indigenous. Public Health is in a position to provide respectful and supportive preventive education and linkage to wrap around supports which may help to positively impact early childhood

development.

- Refer pregnant person to culturally appropriate prenatal/postpartum resources and supports. Consult and refer to Early Years, Public Health if not already connected.

Public Health Follow Up of the Case:

- Cases with **infectious syphilis** and those who are **pregnant** (regardless of staging as vertical transmission may still occur) should be monitored by Public Health for serological response and clinical follow up until no longer considered infectious (refer to tables below as a guide).
- If the syphilis case is pregnant, follow closely until delivery to provide support and to determine fetal/infant outcomes.
- Cases staged with **non-infectious syphilis** should be followed until treatment is completed.
- In situations where the public health case definition and clinical staging differ, serological tests should be monitored based on the staging used for clinical treatment.
- Once Public Health follow-up is complete, ensure that the case understands the importance of ongoing follow-up with their primary care provider, including for serological monitoring if applicable.

The following tables can be used as a guide:

Table 3: Recommended follow-up RPR tests after treatment.

Primary, secondary, and early latent	3, 6, 12 months after treatment*
Late latent and tertiary (excluding neurosyphilis)	12 and 24 months after treatment
Neurosyphilis	6, 12 and 24 months after treatment: <ul style="list-style-type: none">• Patients with CSF abnormalities require follow up CSF at 6 month intervals until normalization of CSF parameters (see Canadian Guidelines on STIs for more information).• Other clinical follow-up may be indicated on a case-by-case basis.
Co-infected with HIV (any stage)	3, 6, 12 and 24 months after treatment* and yearly thereafter.

People treated during pregnancy	<p>Primary, secondary and early latent syphilis:</p> <ul style="list-style-type: none"> • Monthly until delivery if at high risk of re-infection • 1, 3, 6 and 12-months after treatment <p>Late latent syphilis:</p> <ul style="list-style-type: none"> • At time of delivery and 12 and 24 months <p>See Canadian Guidelines on STIs for more information</p>
Babies born to a birth parent with reactive syphilis serology	Refer to Canadian Paediatric Society .

*Some experts recommend follow up testing at 1 month after treatment to ensure that non-treponemal test titre is not rising; a rising titre may be indicative of either treatment failure or re-infection.

Note: Public Health follow up is required for all cases of infectious syphilis and all pregnant people with syphilis regardless of stage. Consultation with specialists is strongly recommended for syphilis cases who are pregnant, living with HIV, have neurological symptoms, or are congenital cases.

Table 4: Adequate RPR response to treatment in infectious syphilis

Primary	4-fold* drop at 6 months and 8-fold drop at 12 months
Secondary	8-fold drop at 6 months and 16-fold drop at 12 months
Early latent	4-fold drop at 12 months

*A four-fold drop = 2- tube drop (i.e., change from 1:32 dilutions to 1:8 dilutions).

Exclusion

In most situations, no exclusion is necessary. If the case's work involves activity that could potentially put the public at risk (e.g. sex trade work), consult Regional Medical Officer of Health (RMOH).

Education of the Case

- Those with infectious syphilis should avoid **all** sexual contact (including oral, anal, vaginal sex) until 7 days after completion of treatment unless otherwise directed. Those with potentially infectious lesions and/or rash should also abstain from sexual contact until symptoms have resolved. If unable to abstain from sexual contact

during a period of infectiousness, the case should follow proper and consistent use of condoms and other barrier methods such as dental dams during any sexual contact.

- Lesions may not be readily apparent (e.g. painless lesions on the internal genital tract in females, intra-anal lesions, etc.) as such, all cases with infectious syphilis should be considered potentially infectious regardless of the presence or absence of obvious lesions.
- Due to risk of reinfection, sexual contact with current partners should also be avoided until 7 days after completion of partners' treatment and resolution of infectious symptoms as described above (if indicated).
- Ensure case understands risk of reinfection. Having syphilis once does not protect a person from getting it again. Following successful treatment, people are still susceptible to re-infection.
- Provide education regarding other sexually transmitted and blood borne infections and prevention measures, including testing and vaccines which may be indicated (e.g. hepatitis B, hepatitis A, HPV, mpox). Encourage case to discuss options for post-exposure prophylaxis with doxycycline (bacterial STIs only) and/or pre-exposure prophylaxis for HIV with a primary care provider, if indicated.
 - Refer to [Nova Scotia Routine Immunization Schedule](#) and [Nova Scotia Vaccine Eligibility for Individuals at High Risk of Acquiring Vaccine Preventable Diseases](#).
- Depending on risk factors identified during interview, provide education regarding harm reduction measures to prevent exposure to communicable diseases in the future.

It is also important for Public Health to provide the above education to health care professionals who may be less familiar with syphilis but play an important clinical role. Additional information that could be shared with health care providers:

- Risk factors associated with syphilis per the Canadian Guidelines on STI include:
 - Barrierless sexual activity involving contact with oral, genital or anal mucosa.
 - Sexual contact with a known case of syphilis or other STBBI.
 - Having multiple sex partners.
 - Substance use, including chemsex.
 - Having experienced street involvement or homelessness.
 - History of syphilis or other STBBIs, particularly HIV.
 - Populations or communities experiencing high prevalence of syphilis (Note that screening for syphilis using a non-treponemal test is routinely performed on immigration applicants to Canada who are older than 15 years).
- Routine prenatal screening for syphilis is an important means of preventing congenital syphilis. Universal screening is recommended during the first trimester or at the first

prenatal visit. Pregnant people in areas with outbreaks, at high risk and/or ongoing risk of infection or reinfection should receive more frequent screening.

- See [Canadian Guidelines on STIs](#) for more information regarding special considerations in pregnancy.
- See [Reproductive Care Program of Nova Scotia](#) for current antenatal screening and testing guidelines.

Congenital Syphilis Case Management

Closely collaborate with pediatric infectious disease specialists to determine the diagnosis and stage of congenital syphilis.

Upon receiving a report of possible congenital syphilis:

- Ensure referral to pediatric infectious disease specialist
- Obtain birth parent history:
 - Was prenatal care received
 - Syphilis serology results
 - Timing of infection
 - Stage of infection
 - History of treatment in pregnancy, including whether treatment was assessed as adequate.
 - Follow up bloodwork to determine if treatment resulted in an adequate serological response.
 - Risk of reinfection during pregnancy.
- Confirm that serology had been collected from both birth parent and infant at the time of delivery for testing (note that cord blood is not suitable).
- Obtain case information such as symptoms (see [congenital syphilis symptoms](#)), staging, and treatment regimen.

Note: In cases where the infant is placed under the care of child protection services, medical information about the birth parent's syphilis diagnosis may be critical to the ongoing protection and monitoring of the infant's health. To ensure effective case management, it is important to facilitate collection and disclosure of relevant health information in accordance with provincial requirements.

In the event of a stillbirth, where the pregnant person had or was suspected to have syphilis, collaborate with clinicians and the Medical Examiner as necessary to determine if meets case definition for syphilitic stillbirth.

Public Health Follow Up

Public Health should follow the infant (or child in the rare event of late congenital syphilis) until syphilis is ruled out (i.e. does not meet case definition) or treatment is completed.

Education

Review [additional considerations for pregnant and/or congenital syphilis cases](#) and ensure parents/caregivers are aware of:

- The role of Public Health and importance of follow up with pediatric infectious disease specialists and serological testing as treatment regimens do not cure every case of congenital syphilis.
- The signs and symptoms of congenital syphilis as treatment regimens do not cure every case of congenital syphilis.
- How to reduce the risk of re-infection (e.g. if birth parent has infectious lesions on breast).

Contact Management

Assess and monitor the birth parent and their sexual partner(s) as per the [Contact Tracing](#) section of this chapter.

Contact Tracing

The goal of contact tracing is rapid identification and investigation of persons who have been identified as contacts of a person who was infectious with syphilis so that they may be tested and treated to prevent further transmission.

Contacts are defined as individuals who had sexual contact (anal, oral or vaginal) with a case during the primary, secondary, and early latent stages of infection. There is an estimated risk of transmission per partner of 60%.

Contact tracing should generally be considered more urgent in situations where there is an imminent risk of a contact transmitting an infection to others. These situations include contacts who are likely to have other unprotected sexual partners or are likely to continue to pass used injection equipment to others, or a contact who is pregnant.

Perinatal contacts (i.e. fetus exposed in utero or during birth if genital lesions present) must also be followed up and referred to a specialist. Transplacental transmission can occur as early as nine weeks gestation and throughout pregnancy. The risk of transmission in untreated pregnancy is 70-100% with primary or secondary syphilis and 40% with early latent syphilis. While less common, vertical transmission can also occur during late latent syphilis.

All contacts within the trace back time periods (see [Table 5](#) below) should be notified of the exposure, referred for testing, and receive treatment (if serology is reactive). Public Health should take the lead in coordinating the process of partner notification with the consent of the person, and confidentially notify partners of their exposure to syphilis. However, if the case strongly prefers to notify their own contacts (or is unwilling/unable to disclose contacts) and if they accept full responsibility for informing their partners of the possibility of exposure to syphilis, then Public Health can provide the necessary information and resources to assist their notification. **Any pregnant contact must be notified and followed up by Public Health.**

Susceptibility

Susceptibility is universal. Following treatment, re-infection may occur with further exposures.

Initiate contact tracing

- Obtain names and information for all contacts who meet the exposure criteria as above. Any pregnant contacts are to be prioritized for rapid notification and must be contacted by Public Health.
- Determine how contacts will be notified. This may be dependent on the nature of the relationship with the contact and/or the social environment they met.

Table 5: Partner notification

Stage of syphilis	Trace-back period
Primary syphilis	3 months*
Secondary syphilis	6 months*
Early latent	1 year*
Late latent/tertiary	Assess long-term partners and children as appropriate; the decision to test these contacts depends on estimated duration of infection in source case.
Congenital (all stages)	Assess birthing parent and their sexual partner(s).

*Trace-back period refers to the time period prior to symptom onset or date of specimen collection (if asymptomatic).

The length of time for the trace-back period should be extended:

1. To include additional time up to the date of treatment.
2. If the index case states that there were no partners during the recommended trace-back period, then the last partner should be notified.
3. If all partners traced (according to recommended trace-back period) test negative, then the partner prior to the trace-back period should be notified.

Presumptive Treatment of Contact

If exposure to a primary, secondary or early latent syphilis case occurred within the past 90 days, presumptive treatment is recommended, especially if contact may be lost to follow-up and/or testing of the contact is not feasible.

Infectious disease specialists should be consulted for further discussion with the contact about presumptive treatment.

For more information about preferred treatment of sexual contacts in the preceding 90 days to primary, secondary, and early latent syphilis refer to: Canadian Guidelines on Sexually Transmitted Infections - [Syphilis Guide: Treatment and Follow Up](#).

Education of Contact (s)

- Explain the importance of following public health recommendations and the rationale for the recommendation(s).
- Advise to avoid **all** sexual contact (including oral, anal, vaginal sex) until infection ruled out or, if applicable, 7 days after completion of presumptive treatment unless otherwise directed. If unable to abstain from sexual contact should follow proper and consistent use of condoms and/or other barrier methods such as dental dams during any sexual contact.
- Provide education regarding the prevention of congenital syphilis for people of childbearing age.
- Provide education regarding other sexually transmitted and blood borne infections and prevention measures, including testing and vaccines which may be indicated (e.g. hepatitis B, hepatitis A, HPV, mpox).
- To determine what vaccines the individual is eligible for refer to [Nova Scotia Routine Immunization Schedule](#) and [Vaccine-Eligibility-for-High-Risk-Conditions](#).
- Depending on risk factors identified during interview, provide education regarding harm reduction measures to prevent exposure to communicable diseases in the future.

Ongoing Public Health follow-up

Ensure that all contacts are appropriately referred, tested and treated when appropriate (if contact names and information were provided by case). Public Health should review contact's test results and other information (i.e. past cases and possible connections) to determine a potential source case and assess whether an outbreak may be occurring.

[General Information Sheet](#)

REFERENCES

- American Academy of Pediatrics (2024). Red Book: 2024–2027 Report of the Committee on Infectious Diseases: Syphilis. <https://publications.aap.org/redbook/book/755/chapter/14082371/Syphilis>
- Fanella, S., Bitnun, A., Barton, M., & Sauve, L. (2024) Canadian Paediatric Society position statement: Diagnosis and management of congenital syphilis – Avoiding missed opportunities. Retrieved from <https://cps.ca/en/documents/position/congenital-syphilis>
- Kimberlin D., et al, editor. Syphilis. In: Red Book: 2018-2021 Report of the Committee on Infectious Diseases. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018. p. 773–88. -
<https://publications.aap.org/redbook/book/755/chapter/14082371/Syphilis?searchresult=1>
- Mabey, D. & Marks, M. (2016). Syphilis. *Control of Communicable Diseases Manual*. Retrieved from <https://ccdm.aphapublications.org/doi/full/10.2105/CCDM.2745.137>
- Manitoba Health. (2023). Syphilis Communicable Disease Management Protocol. Retrieved from <https://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf>
- Public Health Agency of Canada (2023). Infectious syphilis and congenital syphilis in Canada, 2022. *Canada Communicable Disease Report (CCDR)*, 49(10). Retrieved from <https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2023-49/issue-10-october-2023/infectious-congenital-syphilis-canada-2022.html>
- Public Health Agency of Canada. (2024). Canadian Guidelines on Sexually Transmitted Infections: Syphilis. Retrieved from <https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines.html>