

Evaluating Patients For Secondary Syphilis

Secondary Syphilis

Clinical Presentation

- Symptoms typically occur 3-6 weeks after primary stage (can overlap with primary syphilis)
- Resolve spontaneously in 2-10 weeks
- 25% have relapses of symptoms in 1st year
- Rash:** (75-90%) variable morphology ; macular, papular, squamous (scale), pustular (rare), combination; usually nonpruritic; may involve palms & soles in 60%. (Rare case reports of vesicular rash).

Additional Signs & Symptoms of Secondary Syphilis

- Generalized lymphadenopathy: inguinal, axillary & cervical sites most commonly affected (70-90%)
- Constitutional symptoms: most commonly malaise, fever (50-80%)
- Mucous patches: flat patches in oral cavity, pharynx, larynx & genitalia (5-30%)
- Condyloma lata: moist, heaped, wart-like papules in warm intertriginous areas (5-25%)
- Alopecia: patchy hair loss, loss of lateral eyebrows (10-15%)
- Neurosyphilis: visual loss, hearing loss, cranial nerve palsies (<2%)
- Liver & kidney involvement (Rare)

Variable clinical presentation of secondary syphilis

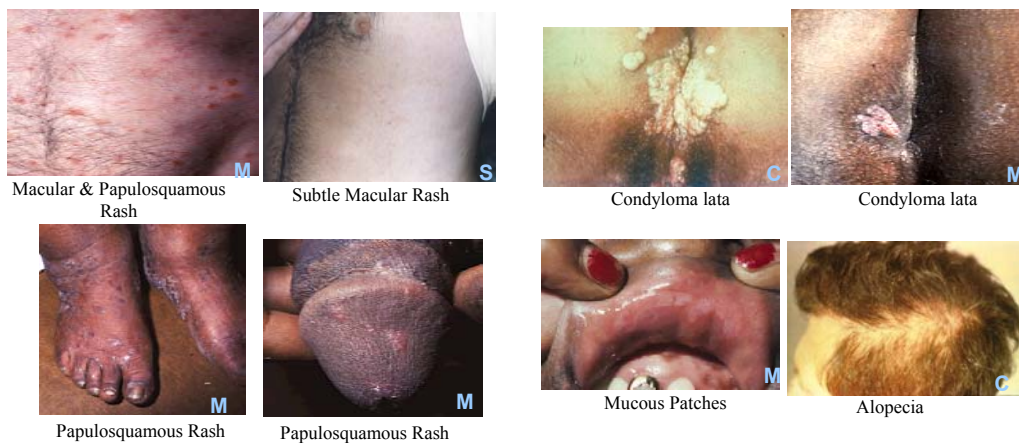


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C Centers for Disease Control.

Acknowledgements

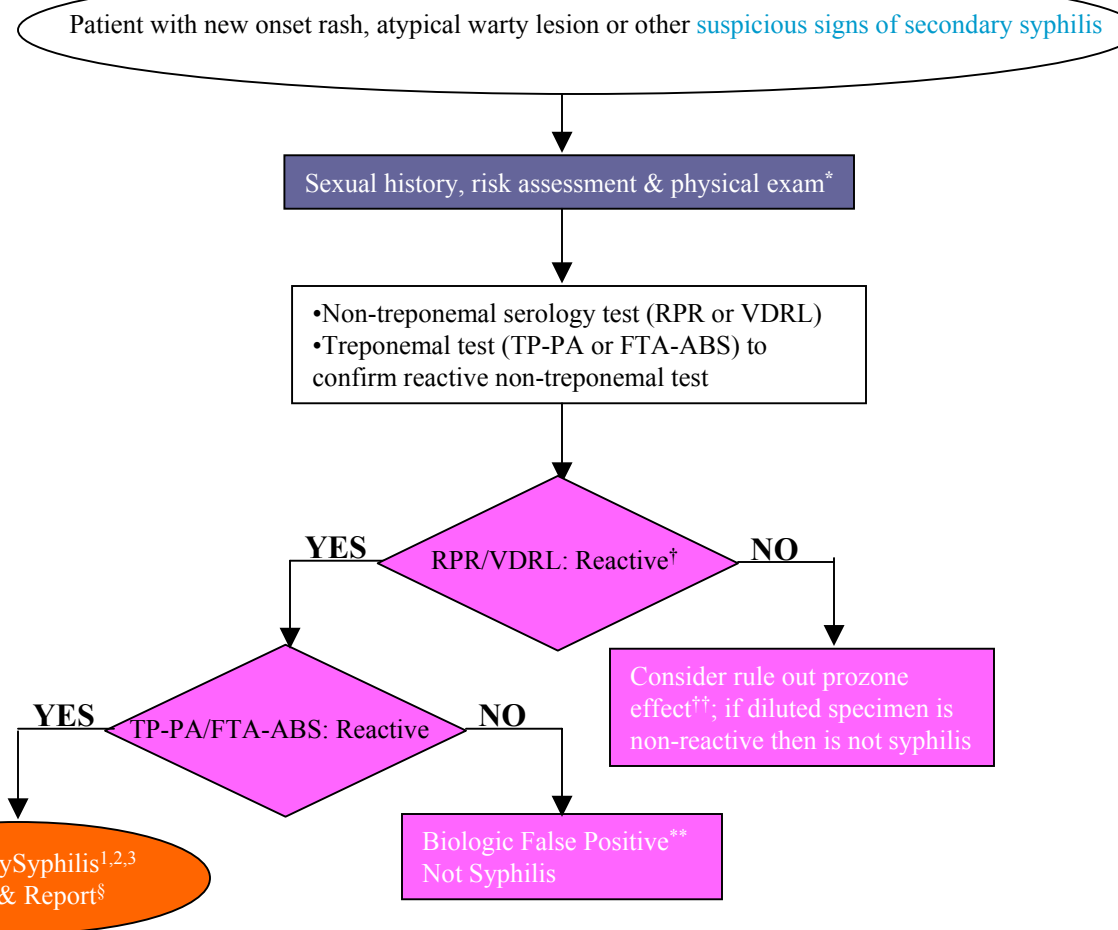
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* , †, ‡, §, **, †† see color coded boxes

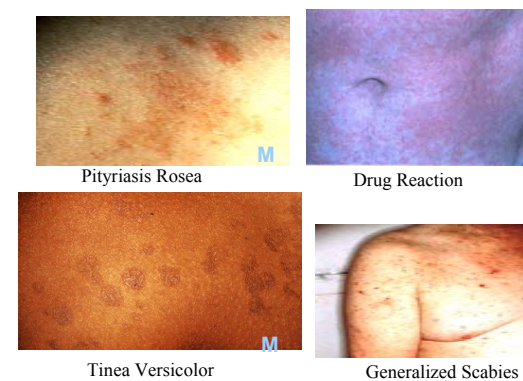
1. An RPR or VDRL drawn at time of treatment should be used for purposes of follow-up to assess treatment response.

2. All patients who have syphilis should be tested for HIV infection and screened for other STDs. If in an area of high HIV prevalence, repeat HIV testing of HIV- negative patients with primary syphilis 3 months after the first HIV test.

3. See CDC 2002 STD Treatment Guidelines: <http://www.cdc.gov/std/treatment/default.htm> and CA STD Treatment Guidelines Grid: <http://www.stdhivtraining.org/pdf/Txguidln2002923.pdf>



Differential Diagnosis of the rash of secondary syphilis includes: Pityriasis Rosea, psoriasis, erythema multiforme, tinea versicolor, scabies, drug eruption, primary HIV infection.



*Sexual History, Risk Assessment & Physical Exam

Sexual History, Risk Assessment (past year)	Physical exam
•gender of partners	•oral cavity
•number of partners (new, anonymous, serodiscordant HIV status)	•lymph node
•types of sexual exposure	•skin of torso
•condom use	•palms & soles
•recent STDs; HIV serostatus	•neurologic
•substance abuse	•genitalia
•HIV risk (men who have sex with men, exchange of sex for money or drugs, injection drug use)	•perianal

History of syphilis

- prior syphilis (& last treatment)
- known contact to an early case of syphilis
- typical signs or symptoms of syphilis in past year
- last serologic test for syphilis

Diagnostic Issues in Secondary Syphilis

- †RPR/VDRL
- RPR & VDRL are ~100% sensitive in secondary syphilis
- RPR or VDRL tests should be quantified to the highest titer so that this result can be used to assess treatment response
- Use same testing method (RPR or VDRL) in sequential testing; cannot compare titer from the two tests
- ††Prozone Effect:
- False negative RPR or VDRL
- Excess antibody blocks antigen-antibody reaction
- Occurs ~1-2% secondary syphilis cases
- Request lab to dilute the serum to at least 1/16 to rule out prozone effect
- **Biologic False Positive
- Reactive RPR or VDRL & Non Reactive TP-PA or FTA-ABS
- Occurs in variety of acute (e.g. hepatitis, post-immunization, varicella) & chronic (e.g. HIV, injection drug use, connective tissue disease, malignancy) conditions

‡Treatment of Secondary Syphilis

Recommended Regimen

- Benzathine Penicillin G 2.4 million units

Alternative Regimens for Non Pregnant Patients who are Penicillin Allergic: close follow-up essential because efficacy not well established

- Doxycycline 100 mg po bid x 2 weeks *or*
- Tetracycline 500 mg po qid x 2 weeks *or*
- Ceftriaxone §§ 1 gm IM or IV qd x 8-10 d *or*
- Azithromycin §§ 2 gm po

§§ efficacy in HIV infected persons not studied so use with extreme caution.

Serologic (RPR/VDRL) and clinical follow-up at 6, 12 months (HIV infected-3,6,9,12,24 months) to assess response . Failure of titer to decline fourfold (e.g., 1:16 to 1:4) within 6 months is probably a treatment failure. See reference 3 (CDC) for follow-up information.