State of Alaska Epidemiology **Bulletin**

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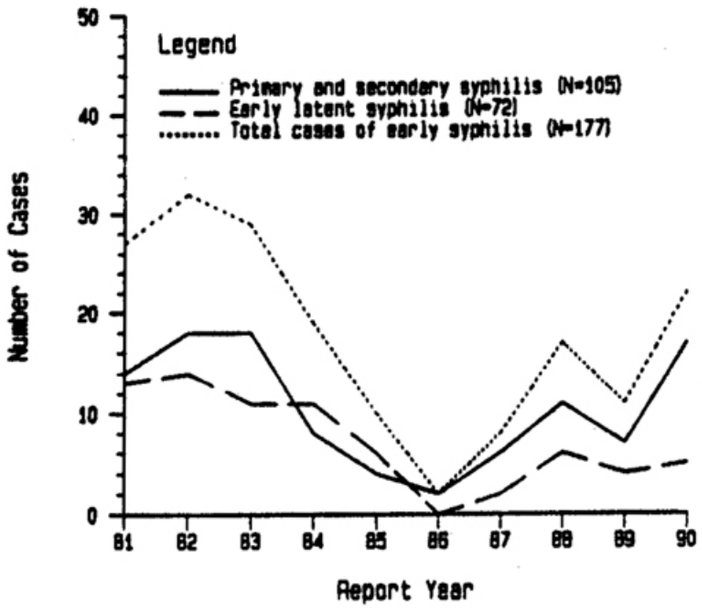
Think Syphilis!

Infectious syphilis (primary, secondary, and early latent stages) is a familiar sight to clinicians working in high-incidence areas of the United States but is not frequently seen in Alaska. The low incidence of syphilis in Alaska has contributed to a decreased index of suspicion for the disease among many health care providers. In 1989, 11 cases of infectious syphilis were reported to the Alaska Division of Public Health. This number doubled in 1990, when 22 cases (a rate of 4.1 cases per 100,000) were reported with the highest number of primary and secondary syphilis cases (17) since 1983.

Reported Cases of Early Syphilis,
Alaska, 1981-1990
N=177



Early syphilis may mimic a variety of dermatologic disorders. Primary disease can be confused with genital herpes, pyoderma, infected abrasions, furuncle, chancroid, granuloma inguinale, lymphogranuloma venereum, and drug eruption. The cutaneous eruptions of secondary syphilis may resemble pityriasis rosea, measles, erythema multiforme, tinea, lichen planus, and other papulosquamous or morbilliform rashes.

The initial lesion (chancre) of primary syphilis is painless and may not be noticed by the patient. It can occur at any body site, the most common being the genitalia, mouth, tongue, and anus. **Darkfield examination of lesion exudate is the best diagnostic tool and is available at the Municipality of Anchorage STD Clinic**. However, indirect evidence of infection may be provided by serologic tests for syphilis (RPR, VDRL). Patients with genital lesions or rashes of uncertain etiology should be screened for syphilis with both a serologic test and a darkfield examination. A presumptive diagnosis can be made in patients with suspected primary or secondary syphilis if these individuals have a reactive serologic test and/or known sexual contact with an infected individual.

A negative serologic test result does not exclude a diagnosis of primary syphilis. Serologic tests may remain nonreactive for as long as 21 days after lesion onset. Thus, patients who have non-reactive serologies and lesions of less than 21 days' duration should be retested. Serologic tests are almost invariably reactive in patients with secondary syphilis. Testing is provided free of charge by the State Public Health Laboratories.

RECOMMENDATIONS:

1. A serologic test for syphilis is recommended for the following:
   - All prenatal patients on initial OB visit. If history indicates increased risk (e.g., multiple sex partners, intravenous drug use), repeat in third trimester and at delivery;
   - All STD patients;
   - All patients presenting with suspicious skin lesions or history of STD exposure;
   - All HIV-positive individuals.
2. A darkfield examination should be performed on all suspicious lesions from which serous fluid can be obtained.
3. Syphilis patients should be treated as follows:
   - Primary, secondary, and latent of less than 1 year's duration: 2.4 million units of Benzathine Penicillin G, or (for non-pregnant allergic patients) doxycycline 100 mg orally twice daily for two weeks.

- Latent syphilis of more than 1 year's duration: 2.4 million units of Benzathine Penicillin G weekly x 3, or (for non-pregnant allergic patients) doxycycline 100 mg orally twice daily for 4 weeks.

Prompt diagnosis of infectious syphilis is essential to halt the further transmission of syphilis and to prevent the occurrence of congenital disease or complications of late syphilis.

For diagnostic consultation, epidemiologic assistance, or to report cases of syphilis, call the STD Program Staff at 561-4406 (Anchorage) or 451-2940 (Fairbanks).

(Contributed by Cheryl Kilgore and Gary Bledsoe, AIDS/STD Program.)