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HEALTH ADVISORY: OCULAR SYPHILIS

FEBRUARY 20, 2015

SITUATIONAL UPDATE

Since December 2014, seven cases of ocular syphilis have been reported in San Francisco. Five of the affected individuals were men who have sex with men (MSM) and six were HIV-infected.

The cause of this cluster of cases is uncertain; an increase in cases was also recently reported in King County, WA. Several of the cases have resulted in a significant and permanent decline in visual acuity. Evidence suggests that certain strains of *Treponema pallidum*, the bacterium that causes syphilis, may be more likely to cause central nervous system (CNS) disease. It is not known whether there are strains of *T. pallidum* that have a greater likelihood of causing ocular infections, but the cluster of cases raises this possibility.

ACTIONS REQUESTED OF CLINICIANS

1. **Test for syphilis in patients presenting with visual complaints**, as well as in patients presenting with genital, oral, or anal ulcers, or rash. The most common eye finding in ocular syphilis is uveitis. Optic neuropathy, keratitis and retinal vasculitis can also occur.
2. **Ask patients with known or suspected syphilis about changes in their vision** and about headache and changes in their hearing (including hearing loss or tinnitus) in order to identify persons who may have ocular syphilis, otologic syphilis, or neurosyphilis.
3. **Refer** patients with syphilis and ocular complaints for immediate ophthalmologic evaluation.
4. **Obtain a lumbar puncture** to evaluate for neurosyphilis in all patients with syphilis and suspected neurologic, otologic or ocular disease.
5. **Promptly treat** patients with ocular syphilis according to CDC guidelines for CNS syphilis, regardless of lumbar puncture results (i.e. intravenous penicillin G or intramuscular procaine penicillin plus oral probencid for 10-14 days) (see: www.cdc.gov/std/treatment/2010/default.htm).
6. **Report suspected syphilis cases within 24 hours of identification.** Call 415-487-5555 or fax a confidential morbidity report (CMR; www.sfcityclinic.org/providers/CMRandReportableDiseaseList.pdf) to SFDPH STD Control 415-431-4628. Please note on the CMR if ocular syphilis is confirmed or suspected. We are investigating all cases of ocular syphilis to better understand the recent increase in reported cases.

ADDITIONAL GUIDANCE RELATED TO DIAGNOSIS AND THERAPY OF SYPHILIS

Please keep in mind the following:

- False negative RPRs can occur in the setting of high RPR titers. If you suspect syphilis and the RPR result is negative, ask the lab to check for prozone phenomenon.
- All patients being evaluated for syphilis should be tested for HIV infection unless they already have a prior HIV diagnosis.
- Initiate penicillin therapy in all patients in whom syphilis is suspected without waiting for laboratory confirmation of the diagnosis.
- For consultation regarding a possible syphilis case, call 415-487-5595

ADDITIONAL GUIDANCE RELATED TO STD PREVENTION

Rates of gonorrhea, chlamydia and syphilis continue to rise in MSM in San Francisco, and >90% of syphilis cases occur among MSM:

- Test for syphilis, gonorrhea, chlamydial infection and HIV ***at least annually*** in all MSM who have had anal or oral sex in the prior year and who are not in a long-term, mutually monogamous sexual relationship[1].
    - MSM at elevated risk (e.g. those who report multiple sex partners or substance use) should be tested every 3 months.
    - Gonorrhea and chlamydial testing should include testing of the pharynx and rectum if those sites have been potentially exposed to infection.
- Test for syphilis ***at each medical visit*** in HIV-infected MSM who are sexually active, unless the patient is in a long-term, mutually monogamous relationship[1]
- Offer HIV pre-exposure prophylaxis (PrEP) to all HIV uninfected men who report unprotected anal sex with multiple partners, or who have a rectal infection or syphilis. For more information about accessing PrEP call: 415-487-5537 or visit: http://www.sfcityclinic.org/services/prep.asp

[1]Medical providers should not assume that patients in long-term relationships are mutually monogamous and should ask patients about their number of sex partners and the gender of those partners.