



# Physician's Newsletter



Communicable Disease Information for Physicians

Winter, 2009-2010

## Communicable Disease Statistics - 2009\*

Reportable Disease	Reported Cases
Preventable by Vaccine	
Pertussis	4
Meningitis	
Aseptic	14
Neisseria	2
Other	0
Enteric	
Campylobacter	73
Cryptosporidiosis	16
E. Coli (all types)	8
Hepatitis A	9
Giardia	30
Salmonella	76
Shigella Infection	54
Sexually Transmissible Diseases	
Chlamydia	774
Gonorrhea	102
Syphilis**	4
Miscellaneous	
Animal Bites	819
Lyme Disease	826
Lead Poisoning (venous>10)	19
Rabies (animals)	21
Tuberculosis	9
Legionella	5

\* As of 12/31/09 - data is provisional

\*\*includes primary, secondary & early latent

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## Syphilis Cases Require Awareness of Diagnosis and Treatment Standards

Sexually Transmissible Diseases (STDs) are important locally, nationally, and globally because of their devastating impact, particularly on women and children and on HIV/AIDS transmission and incidence. Of particular concern is the resurgence of Syphilis (a.k.a., "the Great Impersonator" or "the Great Pox").

Syphilis rates in the US declined by almost 90% between 1990 and 2000, but National Institute of Allergy and Infectious Diseases (NIAID) statistics show the rates jumped by 63% in 2006 when 36,000+ cases were documented. In 2009, in the SEPA District alone, 833 syphilis cases (all stages) were reported, resulting in 8,700 contact investigations. Meanwhile, congenital syphilis cases increased in this area. Chester County had to deal with a case of secondary syphilis which could have proven disastrous, all of which raises the concern that many doctors are not up-to-date on the diagnostic criteria and treatment for syphilis and the need for follow-up visits and "test of cure".

An increase of primary and secondary (P&S) syphilis in males has driven a 54% rate increase for the U.S. from 2002 – 2006. More recently, the number of cases in men increased 11.8% between 2005-06, reflecting the increase in men having sex with men (MSM), among whom 64% of all reported P&S cases occurred. The rate increased nearly 150% among men, and 100% in women.

STD statistics are traditionally understood to be underreported, particularly among the private sector patients, whereas the data for patients seen in public STD clinics are generally complete. This skews the data to seemingly indicate most cases occur among the poor, minority, under-insured public, rather than among the more affluent, middle-class, insured people. However, between 1998-2008, the proportion of P&S

cases reported from sources other than public STD clinics increased from 39% to 66%, underscoring the need for more physicians to be up-to-date about the epidemiology, diagnosis and treatment of syphilis.

Syphilis occurs in primary, secondary, and tertiary stages, with latent periods between. It is infective throughout the primary and secondary stages and possibly into the early latent stage and is usually transmitted by sexual contact, including orogenital and anogenital contacts, as well as contact with infective P&S skin lesions. Prior infection does not confer immunity, and the disease may be accelerated and worsened by coexisting or concurrent HIV infection.

A diagnosis of any individual STD significantly increases the potential for being co-infected with other STDs. Currently, fewer physicians seem to have experience in the diagnosis and treatment of syphilis, so it is crucial to have a high index of suspicion, especially in sexually active adolescents, homosexual patients, in cases with typical mucocutaneous lesions or skin rashes, and a broad range of neurological or other unexplained findings, irrespective of age, gender, or socio-economic status. Reporting of cases and contact tracing have become all the more important.

Syphilis can cause major complications of pregnancy including miscarriages, premature births, stillbirths, neonatal deaths, congenital syphilis, infection of the fetus in >70% of cases, and result in fetal mortality up to 40%.

Diagnosis consists of serologic tests for syphilis (STSs) and darkfield exam of fluids from lesions. STSs consist of screening (reaginic) tests and confirmatory (treponemal)

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### Syphilis cont'd

mal) tests, which may not become positive for 3 to 6 weeks after initial exposure. Thus, a negative test does not rule out the diagnosis until after 6+ weeks. CSF tests are required if neurosyphilis is suspected, and treatment recommendations vary according to the stage of the disease, as well as other patient factors such as pregnancy, penicillin allergy, etc.

Antibiotic treatment (penicillin) should be given parenterally, NOT orally, and the importance of follow-up testing to confirm cure should be explained to the patient. Exams and reaginic re-tests are recommended by CDC at 3, 6, 12 months, and annually thereafter until non-reactive. Failure of titers to decline by 4-fold at 6 months suggests treatment failure and indicates the need for repeat treatment. A significant proportion of P&S cases and those with general paresis or high CSF cell counts may experience a Jarisch-Herxheimer reaction within 6-12 hours of initial antibiotic therapy.

The CCHD will soon mail a summary sheet of CDC's recommended treatment schedules for the various stages of syphilis to area clinicians and hospitals. Meanwhile, current antibiotic treatment regimens are available from medical literature, the CDC's website, and/or infectious disease specialists.



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