# Appendix 1 – Syphilis Care Plan

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| **Care Plan for women with syphilis during pregnancy** |
| **Mother’s Details** |
| Name |  |
| Address |  |
| DOB |  |
| NHI |  |
| Phone number(s) |  |
| Estimated Due Date |  |
| **Labour and birth Team Actions** |
|[ ]  No need to contact on-call paediatric team from syphilis viewpoint *(woman treated prior to current pregnancy and no risk of re-infection)* |
|[ ]  Contact on-call paediatric team when baby is born |
|[ ]  Send placenta for histology and treponemal PCR if syphilis treatment indicated for infant |

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| **Congenital Syphilis Risk – Pre-birth assessment**  |
| **Congenital syphilis unlikely** | **Higher risk of congenital syphilis** |
|[ ]  Maternal treatment completed |[ ]  **Maternal infection: partial or no treatment\*** |
|[ ]  Treated with pencillin |[ ]  **Treated with non-penicillin\*** |
|[ ]  Treatment completed >30 days pre-delivery |[ ]  **Treatment <30 days before delivery\*** |
|[ ]  4x drop in RPR achieved |[ ]  4x drop in RPR not achieved |
|[ ]  Final RPR titre ≤1:4 (VDRL 1:2) |[ ]  Final RPR titre >1 in 4 (VDRL >1 in 2) |
|  |[ ]  Abnormal fetal ultrasound findings |
| **\***The presence of any of the ‘bold asterisk’ factors above means inadequate maternal treatment & requires neonatal treatment at birth. Also, congenital syphilis can still occur despite the absence of the three ‘bold’ factors. |

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| **Maternal Syphilis Care**  |
| [Include stage, treatment & treatment dates, most recent RPR, whether coded or under & any concerns e.g. re-infection risk from partner, treatment late in pregnancy, etc] |
| **STAGE** |
| **Date** | **RPR** | **Treatment given** | **Batch No. & expiry** | **Contact tracing** | **Comments/concerns** |
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| **Advice to Paediatricians**  |
| [ ]  | Low risk: assess infant clinically; if no physical signs of syphilis check ‘**initial blood tests’, OR** |
|[ ]  High risk: treat infant at birth after clinical assessment, ‘**initial blood tests’ and ‘further tests’** |
| Please discuss all infant blood test results with Paediatric Team. |
| Sexual Health Physician: |
| Signed: |
| Date:  |

**Birth Plan Form** to be given to the woman with copies to:

* Paediatric SMO
* LMC
* LMC midwife
* Obstetric SMO
* GP
1. **Physical Signs of Early Congenital Syphilis**
* Jaundice, anaemia, generalised lymphadenopathy, hepatosplenomegaly, non-immune hydrops, pyrexia, failure to move an extremity (pseudoparalysis of Parrot), low birth weight.
* Skin rash: usually maculo-papular but almost any type of rash is possible; palms and soles may be red, mottled and swollen. Vesicles or bullae may be present.
* Condylomata lata (flat, wart-like plaques in moist areas such as perineum).
* Osteochondritis, periosteitis (elbows, knees, wrists).
* Ulceration of nasal mucosa, rhinitis (‘snuffles’ usually after the first week of life).

More than half of neonates with congenital syphilis are normal on initial examination.

1. **Initial Blood Tests**
2. Paired venous blood samples:
* Send a neonatal venous blood sample for syphilis serology; request serum treponemal EIA + RPR + treponemal IgM (available from select NZ Laboratories). Take blood from the neonate, not the umbilical cord
* Send a maternal venous blood sample for serum RPR if no result within last 4 weeks available from the same lab
1. Additional Tests on Infant if Lesions Present\*

Take *T pallidum* polymerase chain reaction (PCR) test from lesions &/or nasal discharge – use viral swab (i.e. as if taking HSV PCR); (available via select NZ laboratories)
*\* lesions of congenital syphilis are infectious; manage infant with contact precautions*

1. **Further Tests if Treatment Indicated (see below)**
* FBC, UCE, LFT, ALT/AST
* Lumbar puncture for CSF: request cell count, protein, CSF VDRL
* Long bone x-rays for osteochondritis & periostitis
* Chest x-ray for cardiomegaly
* Ophthalmology assessment for interstitial keratitis
* Audiology
1. **Indications for Further Tests and Newborn Treatment**
* Mother inadequately treated (Sexual Health/ID consultant will advise).
* Infant has clinical signs consistent with syphilis (Paediatric team will advise).
* Infant’s RPR/VDRL titre 4x mother’s (e.g. mother’s RPR 1:4, infant’s RPR 1:16).
(Sample from mother to be taken no greater than 4 weeks before that of infant)
* Infant has positive treponemal IgM test together with corroborative history, clinical signs.
* Infant has positive T pallidum PCR test together with corroborative history, clinical signs.
* Placental T pallidum PCR positive or histological evidence of congenital infection will also lead to treatment of asymptomatic infants with other normal investigations.
1. **Treatment of Neonates and Children**

Recommended doses of benzylpenicillin (penicillin G)

* Neonate under 7 days 30 mg/kg/dose every 12 hours for 7 days AND every 8 hours thereafter for a total of 10 days
* Neonate 7–28 days 30 mg/kg/dose every 8 hours for 10 days

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| **Infant follow-up** |
| 1. **Proven, highly probable, congenital syphilis**
 | 1. **Asymptomatic, possible, congenital syphilis**
 | 1. **Congenital syphilis less likely**
 |
| 6 weeks | 6 weeks | Month 3 |
|[ ]  Check RPR |[ ]  Check RPR | [ ]  | Repeat RPR and IgM to exclude late seroconversion  |
| [ ]  |  | [ ]  |  |[ ]  Discharge if results negative |
| Month 3 | Month 3 | **OR** |
| [ ]  | Check RPR | [ ]  | Check RPR | [ ]  | RPR and/or IgM positive; discuss with Paediatric Team |
| Month 6 | Month 6 |  |
| [ ]  |  | [ ]  | Check RPR, if negative discharge, if positive repeat at 12 months |  |
| Month 12 | Month 12 |  |
| [ ]  | Check RPR. Discharge if RPR has achieved sustained 4x drop from peak level | [ ]  | RPR negative, no further follow upOR |  |
|  | [ ]  | RPR still positive, discuss with Paediatric Team |  |
|  |  | \*Note: the RPR is usually negative by six months |  |