Appendix 1 – Syphilis Care Plan

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

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.			

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**

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

A. 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.

B. Initial Blood Tests

1) 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

2) 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*

C. 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

D. 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.

E. 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

Infant follow-up

1. Proven, highly probable, congenital syphilis		2. Asymptomatic, possible, congenital syphilis		3. 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 up OR		
		☐	RPR still positive, discuss with Paediatric Team		
			*Note: the RPR is usually negative by six months		