SUMMARY OF CLINICAL STANDARDS FOR ACQUIRED SYphilIS IN HIV-POSITIVE ADULTS

This document has been produced as a response to outbreaks of syphilis in the UK, predominantly amongst men who have sex with men and with a high rate of concomitant HIV infection. Reference should be made to the full supporting document, the Clinical Effectiveness Group (CEG) guidelines for the management of syphilis, and the guidance for management of a sexually transmitted infection (STI) outbreak, all of which can be accessed via the MSSVD website: www.mssvd.org.uk.

Testing for syphilis in HIV-positive individuals

• All HIV-positive patients under regular follow-up should have syphilis serology documented at baseline and at 12 monthly intervals thereafter.

• In an outbreak situation, serological testing for syphilis should be offered to HIV-positive individuals every 3 months, to coincide with HIV follow-up attendances.

In accordance with the Public Health Laboratory Service, an STI outbreak is an overarching term which includes: observed number of cases greater than expected over a defined time period; linked cases of STIs; the need for re-organisation of services or identification of additional resources to manage cases; any case of congenitally acquired infection.

Screening should be performed using serology. The tests of choice are the enzyme immunoassay (EIA) or a treponemal test (such as the TPHA) combined with a reagin test. If primary syphilis is suspected, an EIA-IgM or FTA-IgM test should also be performed. Where lesions consistent with primary or secondary syphilis are recognised clinically, attempts should be made to demonstrate treponemes by dark ground microscopy.

Tests for other sexually transmitted infections

• A full sexual health screen (including investigations for gonorrhoea and chlamydia) should be performed in all patients with suspected or proven syphilis.

• All HIV care providers must offer sexual risk assessment and, if appropriate, screening for sexually transmitted infections every 6 months for HIV-positive patients under follow-up. This may be within the clinic itself or by referral to appropriate colleagues.

A sexual history should be obtained and documented at least every 6 months in those being followed up for HIV.

Treatment regimens

• Treatment of syphilis in HIV-positive individuals should be sufficient to produce treponemical levels in both serum and the CSF to prevent future neurosyphilis.

Details of recommended regimens can be found in the Clinical Effectiveness Group (CEG) guidelines for early and late syphilis (www.mssvd.org.uk).

Penicillin remains the treatment of choice.
A commonly used regimen in the UK is intramuscular Procaine penicillin G 2.0 megaunits (2,000,000 IU) once daily plus oral probenecid 500 mg x4/day for 17-21 days. This is equal to 8 ml of reconstituted Jenacillin A.

The use of Benzathine Penicillin G in HIV infection is open to debate with division of expert opinion. Data demonstrates an 18% failure rate at 6 months in HIV-positive individuals. Second line regimens include oral doxycycline or oral amoxycillin with probenecid.

Ceftriaxone has been used as an alternative agent with reported good CSF penetration, but data is currently limited. There is also insufficient data to support the use of azithromycin at present. Erythromycin is not recommended because of poor CSF penetration.

**Need for lumbar puncture**

- All HIV-infected patients with positive syphilis serology must have a full documented neurological examination.

If neurological symptoms or signs are present, a head scan and lumbar puncture is required to exclude other HIV related conditions. Asymptomatic HIV positive patients do not require a lumbar puncture unless they are going to be treated with a course of antibiotics where there is uncertainty about whether CSF treponemicidal levels will be achieved. Procaine penicillin is known to be treponemicidal in CSF using the regimen above.

**Follow-up**

Unless there are circumstances to suggest inadequate response to initial therapy, all patients should be monitored for evidence of clinical or serological relapse at 3 monthly intervals to one year and then at least annually lifelong. Follow-up should include the reagin titre. Relapse or reinfection should be considered if there is a 4-fold rise in the VDRL or RPR titre.

Partner notification should be instigated for all diagnosed cases, preferably with the input of genitourinary medicine health advisers. Where sexual partners are anonymous and local data suggests an increase in syphilis cases, involvement of public health, health promotion and voluntary sector services should be considered (see PHLS guidelines for managing STI outbreaks; [www.mssvd.org.uk](http://www.mssvd.org.uk)).

**Treatment in individuals of unknown HIV status**

Where an individual is unwilling or unable to have an HIV antibody test performed, but HIV is considered likely on clinical grounds, it is recommended that treatment should be administered as per individuals with proven HIV infection.