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FROM:

STD and Hepatitis Prevention Program
Public Health Services
Health and Human Services Agency
County of San Diego

Contents – STDHEP Update #15

New Syphilis Clusters

During November 2004, there have been **10 cases of early syphilis** (2 primary, 4 secondary and 4 early latent) **reported among young heterosexuals** (most < 25 years of age, 6 females). The clusters occurred in 2 distinct groups – 5 cases in African-Americans in Southeast San Diego and 5 cases in Hispanics in the Chula Vista area. Both clusters have a tangential connection to gang activities and possible methamphetamine drug dealing (6 cases have recently been incarcerated). **All cases in both groups report using crystal methamphetamine. These clusters are extremely worrisome because the potential for community wide spread is very real.** Heterosexual syphilis has been at a very low level since 1996 (15 – 20 cases per year) while at the same time, since there has been little syphilis circulating in the community, the number of persons susceptible to syphilis infection has been growing (untreated syphilis infection provides immunity to reinfection). The previous syphilis outbreak in 1988 – 1992 (250 – 300 cases per year) was mainly among heterosexual African-Americans and was also related to drug use – at that time crack cocaine.

We urge physicians caring for patients with high-risk behaviors to **consider syphilis in the differential diagnosis of genital ulcer disease (primary syphilis)** or **generalized non-pruritic rashes (secondary syphilis) and to order a serologic test for syphilis (RPR or VDRL).** In addition, syphilis serologic screening of patients who may have other STDs (e.g. presenting as penile or vaginal discharge) is currently indicated. **Prompt telephone/fax reporting** of suspect/confirmed primary or secondary syphilis cases will help field investigators in delivering effective partner services. To report a case, please call 619-692-8501 or fax a Confidential Morbidity Report (CMR) to 619-692-8541.

Syphilis Among Men Who Have Sex With Men (MSM) Continues

Through the end of September 2004, 89 cases of infectious syphilis (primary 29, secondary 60) have been reported, which if maintained at this rate, will result in 119 cases for 2004, a 9% increase from 109 cases in 2003. Of the 89 cases, 68 (76%) were MSM and > 50% were HIV positive. Of these 68 infectious stage MSM cases, 69% were diagnosed in the secondary stage, which **suggests that the primary syphilitic ulcer (the most infectious stage) is being missed,**

especially if the lesion was in the oral cavity or anal/rectal area. Since primary syphilitic ulcers are usually painless, they may go unnoticed by the patient.

We encourage physicians who **care for MSM to consider all genital, oral, or anal ulcers as syphilitic until shown otherwise**. The diagnosis of a syphilitic chancre is a clinical diagnosis that is often supported by laboratory results, but not always. **During the first 7 – 10 days from onset of the lesion, the screening serologic test may be negative and usually is negative during the first 3 days.** However, serous fluid from the ulcer can be examined by darkfield microscopy (available at the STD clinic). Specimens can also be tested by the direct fluorescent antibody (DFA) test, which is available at the county public health laboratory. Clinicians need to obtain serous fluid (if necessary, squeeze fluid from the ulcer), blot onto a glass slide, and air-dry. Call the public health lab at 619-692-8500 for submitting instructions.

Since the syphilitic primary lesion may be occult (oral or anal/rectal area) in MSM, **we recommend frequent serologic screening (every 3 – 6 months) of sexually active MSM** and even more frequently for patients with very high-risk behavior – many multiple anonymous partners. Results of such screening may show a low titer (i.e. < 1:8), which should be considered as a possible indication of occult primary syphilis, rather than just an indication of past latent infection of many years duration. In either case, prompt treatment is indicated, but establishing a diagnosis by oral and anal/rectal exam will also aid considerably in syphilis control efforts.

Syphilis Raises HIV Viral Load

A recent study of HIV-infected patients with syphilis showed a significant increase in HIV viral load compared to the viral load levels before acquiring syphilis. The authors state that an increase in a patient's viral load may not be non-adherence with antiviral drugs, but may be an occult syphilis infection. **A serologic test for syphilis is highly recommended as part of the evaluation of an unexpected increase in the HIV viral load level. (AIDS 2004; 18:2075-2079).**

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You can also call Craig Sturak, 619-692-8369, and ask to be added to the list.