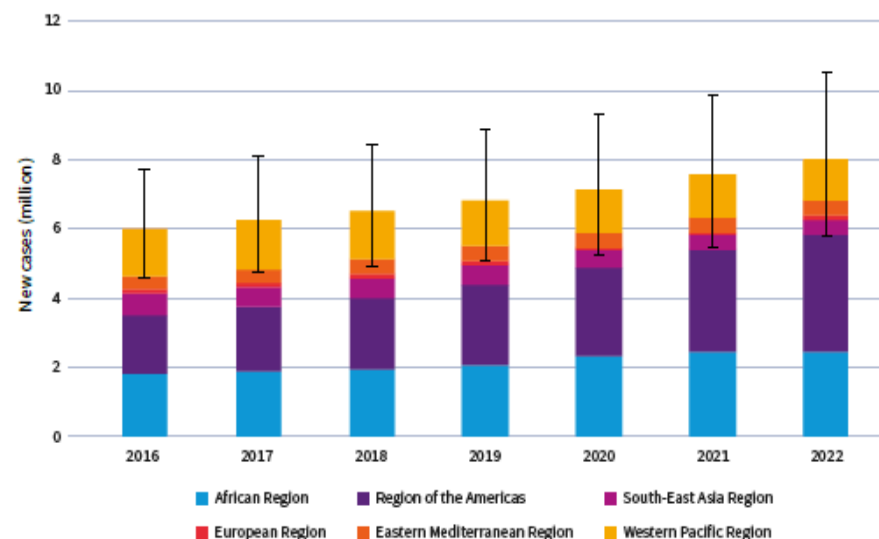

Global perspectives on syphilis diagnosis and treatment

Rationale for global action plan



Global STI response is off-track for reaching its goals

Fig. 6.2 Estimates of the total number of new cases of syphilis among people aged 15–49 years by WHO region, 2016–2022

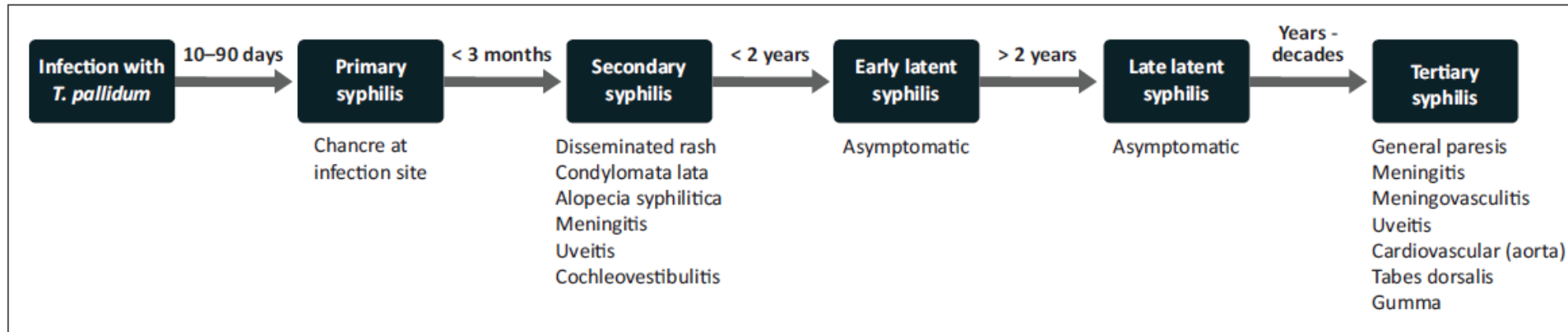


Source: Global HIV, Hepatitis and STIs Programmes (HHS), WHO, 2024.

Syphilis increased by 2 million cases globally in past 10 years

- 74% of cases in the Region of the Americas and African Region
- 71% of congenital syphilis cases in the African region

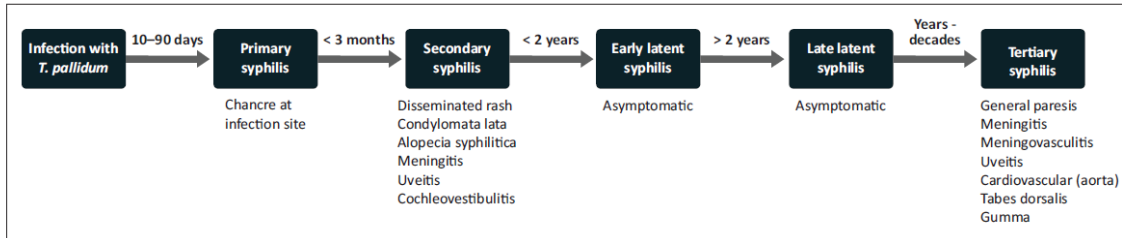
Syphilis pathogenesis determines diagnostic and treatment guidance



Key characteristics

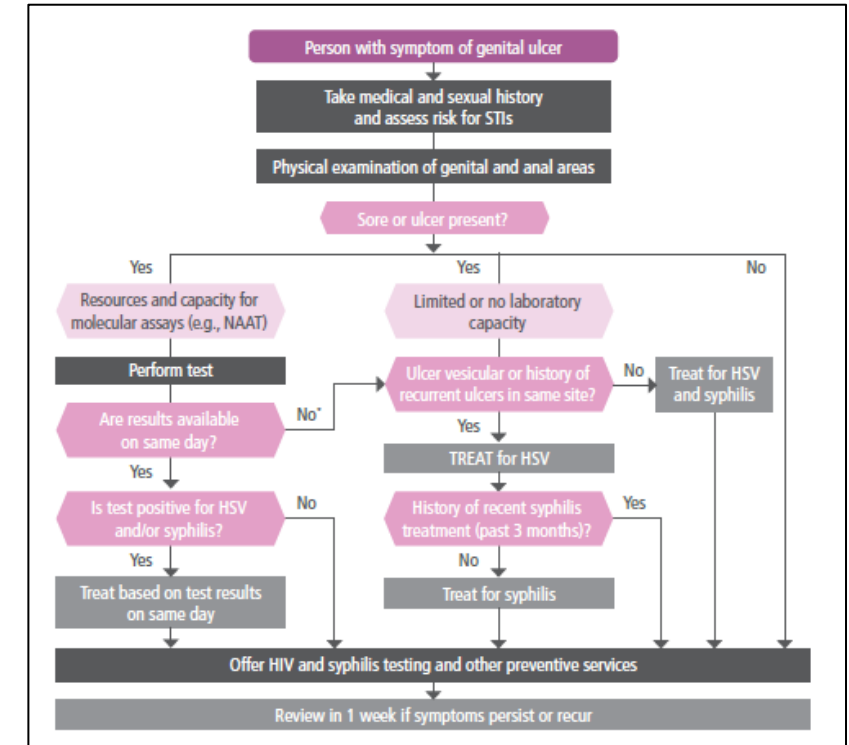
- Primary (genital ulcer) and secondary manifestations may go unnoticed but are highly infectious
- Asymptomatic latent stage that is classified as early or late latent syphilis
- In screening programmes, most cases are considered ‘syphilis of unknown duration’
- Tertiary manifestations are uncommon

Key principle 1: syndromic treatment is essential



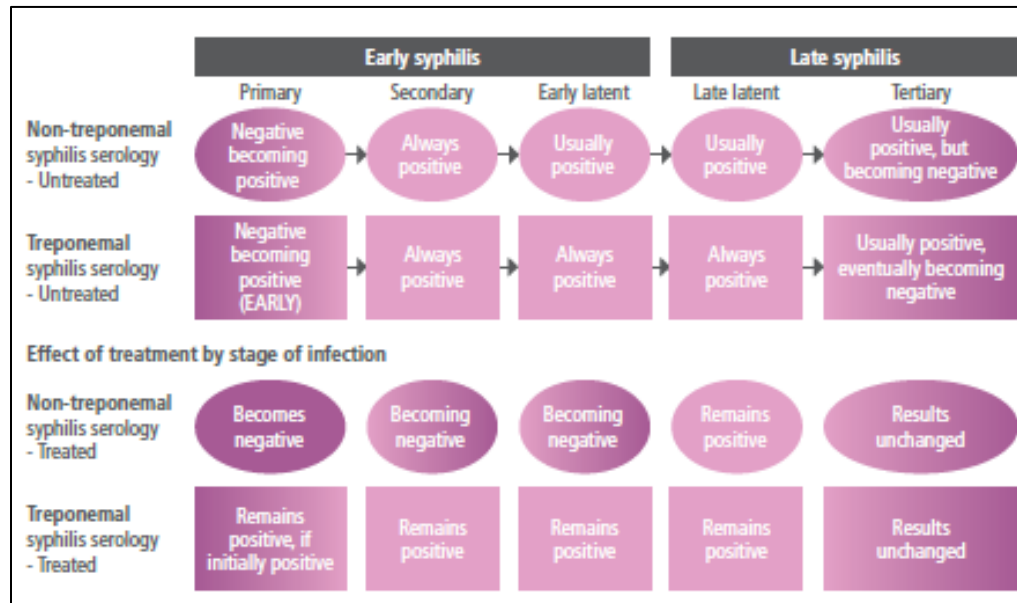
Syndromic treatment of genital ulcer disease

- Syphilis and HSV as the main aetiology (mpox; chancroid)
- Clinical characteristics are non-specific for diagnosis --> do not base treatment decisions on the clinical presentation
- Syndromic management is essential!
- Importance of awareness, education and addressing stigma to ensure that symptomatic people present at healthcare services and receive the appropriate treatment



WHO. Guidelines for the management of symptomatic STIs

Key principle 2: characteristics of syphilis serology



WHO. Guidelines for the management of symptomatic STIs

1. Serological window phase

- Syphilis serology may be negative in people with GUD due to time required to mount sufficient antibody levels
- Syphilis serology (including RDTs) ***should not be used*** to inform treatment decisions in people with GUD

2. Treponemal antibodies remain present lifelong and cross the placenta during pregnancy

- Syphilis treponemal RDTs ***cannot be used*** to diagnose syphilis in previously treated individuals or exposed newborns

3. Syphilis diagnosis requires treponemal and non-treponemal test

- Single syphilis RDT or dual HIV/syphilis RDT ***recommended to support*** the diagnosis of syphilis
- However, given the implications of untreated syphilis, WHO ***recommends direct treatment*** of pregnant women based on a positive treponemal RDT result for presumed syphilis

Key principle 3: BPG is first-line drug

Infection	First-line option	Effective substitutes
Syphilis (early)	Benzathine penicillin G 2.4 million units IM single dose	Doxycycline 100mg orally twice a day for 14 days*
Syphilis (late)	Benzathine penicillin G 2.4 million units IM once weekly for three consecutive weeks	Doxycycline 100mg orally twice a day for 28 days*

*Doxycycline is not recommended in pregnancy. Procaine penicillin and ceftriaxone recommended alternative **in rare cases** that BPG is not available. Follow-up essential.

Further considerations

- BPG is a long-acting formulation – it should not be substituted with other penicillin formations!
- Importance of RPR monitoring and follow-up

Thank you!

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