I. Statement of the Problem:
The current syphilis case definition needs to be updated to reflect changes in laboratory testing and ensure accurate reporting of cases by simplifying the definitions for latent cases.

II. Background and Justification:

Background

Syphilis is a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*. Syphilis is passed from person to person through direct contact with a syphilitic chancre. Chancres occur mainly on the external genitals, vagina, anus, or in the rectum but can also occur on the lips and in the mouth. Transmission of the organism occurs during vaginal, anal, or oral sex. Pregnant women with the disease can transmit it through the placenta to the fetus or at birth to the neonate. Many people infected with syphilis do not have any symptoms for years, yet remain at risk for late complications if they are not treated. Although transmission occurs from persons with chancres who are in the primary or secondary stage, many of these chancres are unrecognized. Thus, transmission may occur from persons who are unaware of their infection.

In the United States, testing for syphilis traditionally has consisted of initial screening with an inexpensive nontreponemal test, followed by retesting reactive specimens with a more specific treponemal test. Nontreponemal tests, such as the Rapid Plasma Reagin (RPR) test and Venereal Disease Research Laboratory (VDRL) test, detect antibodies to cardiolipin and are not specific for treponemal infection. Nontreponemal tests are more likely than treponemal tests to produce nonreactive results after treatment; therefore, reactive results from nontreponemal tests are more reliable indicators of untreated infection. Quantitative nontreponemal tests are also used to monitor responses to treatment or to indicate new infections.

Treponemal tests detect antibodies specific to *Treponema pallidum*. In addition to *Treponema pallidum*, which causes syphilis, other treponemal subspecies (e.g., *pertenue*, which causes yaws, and *carateum*, which causes pinta) also can produce reactive results to treponemal tests, but these subspecies are rare in the United States. A reactive treponemal test result indicates that treponemal infection has occurred at some point in the past but cannot distinguish between treated and untreated infections. As such, treponemal tests can produce reactive results for life, even after adequate treatment for syphilis. Both treponemal and nontreponemal tests can produce nonreactive results when the infection has been acquired recently; approximately 20% of test results are negative when patients have primary syphilis.

In the last five years, there has been an increase in the adoption of automated treponemal tests by laboratories which has resulted in the syphilis testing algorithm being reversed. Many laboratories now use an automated treponemal test as the initial screening test followed by a nontreponemal test. While this algorithm is more time and cost effective for laboratories, it does have a ~14–40% false-positive rate with a second treponemal test often being used to help determine what clinical action should be taken. In addition to this change, polymerase chain reaction tests for syphilis can be performed by clinical laboratories that have developed their own tests and have conducted verification studies in accordance with the Clinical Laboratories Improvement Amendment (CLIA).

Justification
The laboratory criteria for syphilis diagnosis need to be updated to reflect the addition of new diagnostic tests and the removal of tests not used. Other changes are needed to ensure cases are counted accurately and consistently across all jurisdictions.

III. Statement of the desired action(s) to be taken:

1. Utilize standard sources (e.g. reporting*) for case ascertainment for syphilis. Surveillance for syphilis should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of syphilis.

<table>
<thead>
<tr>
<th>Source of data for case identification</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population-wide</td>
</tr>
<tr>
<td>Clinician reporting</td>
<td>X</td>
</tr>
<tr>
<td>Laboratory reporting</td>
<td>X</td>
</tr>
<tr>
<td>Reporting by other entities (e.g., hospitals, veterinarians, pharmacies)</td>
<td>X</td>
</tr>
<tr>
<td>Death certificates</td>
<td>X</td>
</tr>
<tr>
<td>Hospital discharge or outpatient records</td>
<td>X</td>
</tr>
<tr>
<td>Extracts from electronic medical records</td>
<td>X</td>
</tr>
<tr>
<td>Telephone survey</td>
<td></td>
</tr>
<tr>
<td>School-based survey</td>
<td></td>
</tr>
<tr>
<td>Other ______________________________</td>
<td></td>
</tr>
</tbody>
</table>

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for syphilis and add this condition to the Nationally Notifiable Condition List.

☐ 2a. Immediately notifiable, extremely urgent (within 4 hours)
☐ 2b. Immediately notifiable, urgent (within 24 hours)
☑ 2c. Routinely notifiable

CSTE recommends that all States and Territories enact laws (statue or rule/regulation as appropriate) to make this disease or condition reportable in their jurisdiction. Jurisdictions (e.g. States and Territories) conducting surveillance (according to these methods) should submit case notifications** to CDC.

CSTE recommends that all jurisdictions (e.g. States or Territories) with legal authority to conduct public health surveillance follow the recommended methods as outlined above.

Terminology:
* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health
**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

CSTE requests that CDC adopt this revised, standardized reporting definition for syphilis, including the following changes:

1. Update laboratory criteria for all categories
2. Update clinical description for all categories
3. Remove or consolidate some reporting categories
IV. Goals of Surveillance:
To provide information on the temporal, geographic, and demographic occurrence of syphilis to facilitate its prevention and control.

V. Methods for Surveillance: Surveillance for syphilis should use the recommended sources of data and the extent of coverage listed in Table III.

<table>
<thead>
<tr>
<th>Source of data for case identification</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-wide Sentinel sites</td>
<td></td>
</tr>
<tr>
<td>Clinician reporting</td>
<td>X</td>
</tr>
<tr>
<td>Laboratory reporting</td>
<td>X</td>
</tr>
<tr>
<td>Reporting by other entities (e.g., hospitals, veterinarians, pharmacies)</td>
<td>X (e.g. STD clinics)</td>
</tr>
<tr>
<td>Death certificates</td>
<td>X</td>
</tr>
<tr>
<td>Hospital discharge or outpatient records</td>
<td>X</td>
</tr>
<tr>
<td>Extracts from electronic medical records</td>
<td>X</td>
</tr>
<tr>
<td>Telephone survey</td>
<td></td>
</tr>
<tr>
<td>School-based survey</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

VI. Criteria for case identification:

A. Narrative: A description of suggested criteria for case ascertainment of syphilis.

Report to public health authorities any of the following laboratory test results:

- Demonstration of *Treponema pallidum* in clinical specimens by darkfield microscopy
- Demonstration of *T. pallidum* in late lesions by special stains
- Reactive polymerase chain reaction (PCR) or equivalent direct molecular tests
- Reactive nontreponemal serologic tests:
  - Reactive Venereal Disease Research Laboratory [VDRL] serologic test
  - Reactive rapid plasma reagin [RPR] serologic test
  - Reactive results with equivalent serologic methods
- Reactive treponemal serologic tests:
  - Reactive fluorescent treponemal antibody absorbed [FTA-ABS] serologic test
  - Reactive *T. pallidum* particle agglutination [TP-PA] serologic test
  - Reactive treponemal enzyme immunoassay (EIA) serologic test
  - Reactive treponemal chemiluminescence immunoassay (CIA) serologic test
  - Reactive results with equivalent serologic methods
- Reactive Venereal Disease Research Laboratory [VDRL] in a specimen of cerebrospinal fluid
- Reactive fluorescent treponemal antibody absorbed-19S-IgM antibody test or IgM enzyme-linked immunosorbent assay in an infant

NOTE: Treponemal and/or nontreponemal tests are often performed to confirm or follow up a reactive serologic test for syphilis. All such confirmatory test results (both reactive and nonreactive) should be reported when available, but their availability should not delay report of an initial reactive serologic test result. All reactive results should be reported regardless of treatment status of the patient.
If associated with one or more of the above laboratory tests, report to public health authorities any of the following clinical presentations:

- Ulcerative lesion (e.g. chancre)
- Localized or diffuse mucocutaneous lesions (non-pruritic macular, maculopapular, papular or pustular lesions), generalized lymphadenopathy, mucous patches, condyloma lata, alopecia
- Evidence of congenital syphilis on physical examination
- Evidence of congenital syphilis on radiographs of long bones
- Syphilitic lesions of the cardiovascular system, skin, bone or other tissue
- In a potential case of syphilis with neurologic manifestations, clinical symptoms or signs consistent with neurosyphilis without other known causes AND an elevated CSF protein or CSF leukocyte count, in the absence of other known causes

Report to public health authorities any of the following epidemiologic risk factors:

- In a potential case of congenital syphilis, an infant whose mother had untreated or inadequately treated syphilis at delivery, regardless of signs in the infant. (Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.)

Report any death certificate that lists syphilis as a cause of death or a significant condition contributing to death.

### B. Table of criteria to determine whether a case should be reported to public health authorities

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Syphilis of Any Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical presentation</strong></td>
<td></td>
</tr>
<tr>
<td>Ulcerative lesion (e.g. chancre)</td>
<td>C</td>
</tr>
<tr>
<td>Localized or diffuse mucocutaneous lesions (non-pruritic macular, maculopapular, papular or</td>
<td>C</td>
</tr>
<tr>
<td>pustular lesions), generalized lymphadenopathy, mucous patches, condyloma lata, alopecia</td>
<td></td>
</tr>
<tr>
<td>Evidence of congenital syphilis on physical examination</td>
<td>C</td>
</tr>
<tr>
<td>Evidence of congenital syphilis on radiographs of long bones</td>
<td>C</td>
</tr>
<tr>
<td>Syphilitic lesions of the cardiovascular system, skin, bone or other tissue</td>
<td>C</td>
</tr>
<tr>
<td>Neurologic manifestations, clinical symptoms or signs consistent with neurosyphilis</td>
<td>C</td>
</tr>
<tr>
<td>without other known causes</td>
<td></td>
</tr>
<tr>
<td>Any death certificate that lists syphilis as a cause of death or a significant condition</td>
<td>S</td>
</tr>
<tr>
<td>contributing to death.</td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory Findings</strong></td>
<td></td>
</tr>
<tr>
<td>Demonstration of <em>Treponema pallidum</em> in clinical specimens by darkfield microscopy</td>
<td>S</td>
</tr>
<tr>
<td>Demonstration of <em>T. pallidum</em> in late lesions by special stains</td>
<td>S</td>
</tr>
<tr>
<td>Reactive polymerase chain reaction test (PCR) or equivalent direct molecular methods</td>
<td>S</td>
</tr>
<tr>
<td>Reactive non-treponemal serologic test (Venereal Disease Research Laboratory [VDRL], rapid</td>
<td>S</td>
</tr>
<tr>
<td>plasma reagin [RPR], or equivalent serologic methods)</td>
<td></td>
</tr>
</tbody>
</table>
### Reactive Treponemal Serologic Tests
- **Reactive Treponemal Serologic Test (FTA-ABS)**: Fluorescent Treponemal Antibody Absorbed Test
- **Reactive Venereal Disease Research Laboratory (VDRL) Test**: Venereal Disease Research Laboratory Test in a specimen of cerebrospinal fluid
- **Reactive Fluorescent Treponemal Antibody Absorbed (FTA-ABS)**: Fluorescent Treponemal Antibody Absorbed Test or IgM enzyme-linked immunosorbent assay (ELISA)
- **An Elevated CSF Protein or CSF Leukocyte Count**: An elevated CSF protein or CSF leukocyte count in the absence of other known causes

### Epidemiological Risk Factors
- **An Infant whose Mother had Untreated or Inadequately Treated Syphilis at Delivery**: An infant whose mother had untreated or inadequately treated syphilis at delivery, regardless of signs in the infant. (Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.)

### Notes:
- **S**: This criterion alone is sufficient to report a case.
- **C**: This finding corroborates (i.e., supports) the diagnosis of—or is associated with—syphilis, but is not required for reporting.

### C. Disease-specific data elements
Disease-specific data elements to be included in the initial report are listed below.

- Non-treponemal serologic test titer
- Stage of syphilis
- Pregnancy status
- HIV Status
- Gender of sex partners

**NOTE**: Public health authorities do not expect that an initial report will contain all the information necessary for case investigation and case classification. The disease-specific data elements listed here are meant to assist public health authorities in prioritizing case interviews.

### VII. Case Definition for Case Classification:
All cases of probable or confirmed syphilis should be reported, regardless of treatment or interview status. Stage determination should be based on available clinical and serological information. Syphilis cases should be categorized (e.g., probable or confirmed) and reported by stage at the time of initial examination (which is often the time of initial specimen collection), not at the time of treatment or interview.

### A. Narrative: Description of criteria to determine how a case should be classified.
Syphilis is a complex sexually transmitted disease that has a highly variable clinical course. Adherence to the following surveillance case definitions will facilitate understanding the epidemiology of this disease across the U.S.

- **Syphilis, primary**
- **Syphilis, secondary**
- **Syphilis, early latent**
- **Syphilis, late latent**
- **Syphilis, late, with clinical manifestations**
- **Neurosyphilis**
- **Syphilitic stillbirth**
- **Syphilis, congenital**

**Syphilis, primary**
Clinical description

A stage of infection with *Treponema pallidum* characterized by one or more ulcerative lesions (e.g. chancre), which might differ considerably in clinical appearance.

Laboratory criteria for diagnosis

- Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, or by polymerase chain reaction (PCR) or equivalent direct molecular methods.

Case classification

**Probable:** a case that meets the clinical description of primary syphilis with a reactive serologic test (nontreponemal: Venereal Disease Research Laboratory [VDRL], rapid plasma reagin [RPR], or equivalent serologic methods; treponemal: fluorescent treponemal antibody absorbed [FTA-ABS], *T. pallidum* particle agglutination [TP-PA], enzyme immunoassay [EIA], chemiluminescence immunoassay [CIA], or equivalent serologic methods).  

**Confirmed:** a case that meets the clinical description of primary syphilis that is laboratory confirmed

**Syphilis, secondary**

Clinical description

A stage of infection caused by *T. pallidum* characterized by localized or diffuse mucocutaneous lesions (e.g., rash — such as non-pruritic macular, maculopapular, papular, or pustular lesions), often with generalized lymphadenopathy. Other symptoms can include mucous patches, condyloma lata, and alopecia. The primary ulcerative lesion may still be present. Because of the wide array of symptoms possibly indicating secondary syphilis, serologic tests for syphilis and a thorough sexual history and physical examination are crucial to determining if a case should be classified as secondary syphilis.

Laboratory criteria for diagnosis

- Demonstration of *T. pallidum* in clinical specimens by darkfield microscopy, or by polymerase chain reaction (PCR) or equivalent direct molecular methods.

Case classification

**Probable:** a case that meets the clinical description of secondary syphilis with a nontreponemal (VDRL, RPR, or equivalent serologic methods) titer $\geq 4$ AND a reactive treponemal test (FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods).

**Confirmed:** a case that meets the clinical description of secondary syphilis (with at least one sign or symptom) that is laboratory confirmed

**Syphilis, early latent**

Clinical description

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1 These treponemal tests supersede older testing technologies, including microhemagglutination assay for antibody to *T. pallidum* [MHA-TP].

13-ID-04
A subcategory of latent syphilis (a stage of infection caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs) when initial infection has occurred within the previous 12 months.

**Case classification**

**Probable:** A person with no clinical signs or symptoms of syphilis who has one of the following:

- No past diagnosis of syphilis, AND a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), AND a reactive treponemal test (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods),
  
  **OR**

- A current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.

AND evidence of having acquired the infection within the previous 12 months based on one or more of the following criteria:

- Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months

- Documented seroconversion of a treponemal test during the previous 12 months

- A history of symptoms consistent with primary or secondary syphilis during the previous 12 months

- A history of sexual exposure to a partner within the previous 12 months who had primary, secondary, or early latent syphilis (documented independently as duration < 12 months)

- Only sexual contact was within the last 12 months (sexual debut)

There is no confirmed case classification for early latent syphilis.

**Syphilis, late latent**

**Clinical description**

A subcategory of latent syphilis (a stage of infection caused by *T. pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs) when initial infection has occurred >12 months previously.

**Case classification**

**Probable:** A person with no clinical signs or symptoms of syphilis who has one of the following:

- No past diagnosis of syphilis, AND a reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic methods), AND a reactive treponemal test (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods),
  
  **OR**

- A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.

AND who has no evidence of having acquired the disease within the preceding 12 months (see Syphilis, early latent).
There is no confirmed case definition for late latent syphilis.

**Syphilis, late, with clinical manifestations (including late benign syphilis and cardiovascular syphilis)**

**Clinical description**

Clinical manifestations of late syphilis may include inflammatory lesions of the cardiovascular system, (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis) or other tissue. Rarely, other structures (e.g., the upper and lower respiratory tracts, mouth, eye, abdominal organs, reproductive organs, lymph nodes, and skeletal muscle) may be involved. Late syphilis usually becomes clinically manifest only after a period of 15–30 years of untreated infection. If only neurologic manifestations of syphilis (e.g., tabes dorsalis, dementia) are present and infection occurred more than 12 months ago, the case should be reported as “late syphilis”.

**Laboratory criteria for diagnosis**

Demonstration of *T. pallidum* in late lesions by special stains (although organisms are rarely visualized in late lesions), or equivalent methods, or by polymerase chain reaction (PCR) or equivalent direct molecular methods.

**Case classification**

*Probable:* characteristic abnormalities or lesions of the cardiovascular system (e.g., aortitis, coronary vessel disease), skin (e.g., gummatous lesions), bone (e.g., osteitis), or other tissue AND a reactive treponemal test (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods), in the absence of other known causes of these abnormalities. CSF abnormalities and clinical symptoms or signs consistent with neurologic manifestations of syphilis might be present.

*Confirmed:* a case that meets the clinical description of late syphilis that is laboratory confirmed
Neurosyphilis

Note

**Neurosyphilis can occur at any stage of syphilis.** If the patient has neurologic manifestations of syphilis, the case should be reported with the appropriate stage of infection (as if neurologic manifestations were not present) and “neurologic manifestations” should be noted in the case report data. If no other stage is appropriate, the case should be staged as “late, with clinical manifestations”.

Clinical description

Infection of the central nervous system with *T. pallidum*, as evidenced by manifestations including syphilitic meningitis, meningovascular syphilis, optical involvement including interstitial keratitis and uveitis\(^2\), general paresis, including dementia, and tabes dorsalis.

Laboratory criteria for diagnosis

- A reactive VDRL in cerebrospinal fluid (CSF) **AND** either 1.) a reactive treponemal serologic test for syphilis (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods) **OR** 2.) a reactive non-treponemal serologic test for syphilis (VDRL, RPR, or equivalent serologic method).

Case classification

**Probable:** syphilis of any stage with a negative VDRL test in CSF specimen and either 1.) a reactive treponemal serologic test for syphilis (e.g., FTA-ABS, TP-PA, EIA, CIA, or equivalent serologic methods) **OR** 2.) a reactive non-treponemal serologic test for syphilis (VDRL, RPR, or equivalent serologic method), **AND** both the following:

- Elevated CSF protein\(^\dagger\) or leukocyte count\(^\dagger\) in the absence of other known causes of these abnormalities **AND**
- Clinical symptoms or signs consistent with neurosyphilis without other known causes for these clinical abnormalities

**Confirmed:** syphilis of any stage that meets the laboratory criteria for neurosyphilis

\(^\dagger\) CSF protein >50 mg/dL; >5 white blood cells/cubic millimeter CSF; in HIV-positive individuals, these parameters are less specific

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**Syphilitic Stillbirth**

*Clinical case definition*

A fetal death that occurs after a 20-week gestation or in which the fetus weighs greater than 500 g and the mother had untreated or inadequately treated* syphilis at delivery

**Comment**

For reporting purposes, syphilitic stillbirths should be reported as cases of congenital syphilis.

*Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.

**Syphilis, Congenital**

*Clinical description*

A condition caused by infection in utero with *Treponema pallidum*. A wide spectrum of severity exists, and only severe cases are clinically apparent at birth. An infant or child (aged less than 2 years) may have signs such as hepatosplenomegaly, rash, condyloma lata, snuffles, jaundice (nonviral hepatitis), pseudoparalysis, anemia, or edema (nephrotic syndrome and/or malnutrition). An older child may have stigmata (e.g., interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints).

*Laboratory criteria for diagnosis*

Demonstration of *Treponema pallidum* by darkfield microscopy, fluorescent antibody, or other specific stains in specimens from lesions, placenta, umbilical cord, or autopsy material.

**Case classification**

Probable: a condition affecting an infant whose mother had untreated or inadequately treated* syphilis at delivery, regardless of signs in the infant, OR an infant or child who has a reactive treponemal test for syphilis AND any one of the following:

- Any evidence of congenital syphilis on physical examination
- Any evidence of congenital syphilis on radiographs of long bones
- A reactive Venereal Disease Research Laboratory (VDRL) test in a specimen of CSF
- An elevated CSF protein or CSF leukocyte count (without other cause)
- A reactive fluorescent treponemal antibody absorbed--19S-IgM antibody test or IgM enzyme-linked immunosorbent assay

Confirmed: a case that is laboratory confirmed

**Comment**

Congenital and acquired syphilis may be difficult to distinguish when a child is seropositive after infancy. Signs of congenital syphilis may not be obvious, and stigmata may not yet have developed. Abnormal values for CSF VDRL, cell count, and protein, as well as IgM antibodies, may be found in either congenital or acquired syphilis. Findings on radiographs of long bones may help because radiographic changes in the metaphysis and epiphysis are considered classic signs of congenitally acquired syphilis. The decision may ultimately be based on maternal history and clinical judgment. In a young child, the possibility of sexual abuse should be considered as a cause of acquired rather than congenital syphilis, depending on the clinical picture. For reporting purposes, congenital syphilis includes cases of congenitally acquired syphilis among infants and children as well as syphilitic stillbirths.

*Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.

**Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance**

Specific criteria and time periods for new cases by stage are included in the above case definitions.
B. Classification Tables

Criteria for defining a case of syphilis.

<table>
<thead>
<tr>
<th>Case Definition</th>
<th>Confirmed</th>
<th>Probable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Latent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criterion</td>
<td>1 2</td>
<td>Neuro*</td>
</tr>
<tr>
<td>Clinical presentation</td>
<td>Ulcerative lesion (e.g. chancre)</td>
<td>N C</td>
</tr>
<tr>
<td></td>
<td>N C</td>
<td>A A</td>
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<td></td>
<td>C</td>
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</tbody>
</table>
A child with stigmata of congenital syphilis (e.g., interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson teeth, saddle nose, rhagades, or Clutton joints)

Evidence of congenital syphilis on radiographs of long bones (e.g., metaphyseal and epiphyseal changes)

**Laboratory Findings**

**Demonstration of *Treponema pallidum* in clinical specimens by darkfield microscopy**

**Reactive polymerase chain reaction test (PCR) or equivalent direct molecular methods**

**Reactive non-treponemal serologic test (Venereal Disease Research Laboratory [VDRL], rapid plasma regain [RPR], or equivalent serologic methods)**

**Reactive Venereal Disease Research Laboratory [VDRL], rapid plasma regain [RPR], or equivalent serologic test with a titer ≥4**

**Reactive Venereal Disease Research Laboratory [VDRL], rapid plasma reagin [RPR], or equivalent serologic test demonstrating a fourfold or greater increase in titer**

**Reactive Venereal Disease Research Laboratory [VDRL] test in a specimen of cerebrospinal fluid**

**Reactive treponemal serologic test (fluorescent treponemal antibody absorbed [FTA-ABS], T. pallidum particle agglutination [TP-PA]), enzyme immunoassay [EIA], chemiluminescence immunoassay [CIA], or equivalent serologic methods)**

**Elevated CSF protein or CSF leukocyte count in absence of other known cause**
<table>
<thead>
<tr>
<th>Demonstration of <em>T. pallidum</em> in late lesions by special stains</th>
<th>O</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstration of Treponema pallidum by darkfield microscopy, fluorescent antibody, or other specific stains in specimens from lesions, placenta, umbilical cord, or autopsy material</td>
<td>N</td>
<td>A</td>
</tr>
<tr>
<td>Reactive fluorescent treponemal antibody absorbed –19S-IgM antibody test or IgM enzyme-linked immunosorbent assay</td>
<td>O</td>
<td></td>
</tr>
</tbody>
</table>

**Epidemiological Risk Factors**

| An infant whose mother had untreated or inadequately treated syphilis at delivery, regardless of signs in the infant. (Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.) | O |  |
| A fetal death that occurs after a 20-week gestation or in which the fetus weighs greater than 500 g and the mother had untreated or inadequately treated syphilis at delivery. (Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.) | O |  |

**Criteria for assessing the stage of latent syphilis**

| No history of syphilis diagnosis | O | O |
| Past history of syphilis therapy | O* | O* |
| History of symptoms consistent with primary or secondary syphilis within the previous 12 months | O | A |
| History of sexual exposure to a partner who had confirmed or probable primary or secondary syphilis or probable early latent syphilis (documented independently as duration less than 12 months) | O | A |
| Seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months | O | A |
Documented seroconversion of a treponemal test during the previous 12 months

Only sexual contact was within the last 12 months (sexual debut)

Notes:
* When reporting neurosyphilis to CDC, the case should be reported as the stage of infection with “neurologic manifestations present” noted in the case report data.

N = This criterion in conjunction with all other “N” and any “O” criteria in the same column is required to classify a case.

O = At least one of these “O” criteria in each category in the same column (e.g., clinical presentation and laboratory findings)—in conjunction with all other “N” criteria in the same column—is required to classify a case.

A = This criterion must be absent (i.e., NOT present) for the case to meet the case definition.

C = This finding corroborates (i.e., supports) the diagnosis of—or is associated with—syphilis, but is not included in the case definition.

† If there is a history of past therapy for syphilis, a fourfold increase in nontreponemal titer must be present.

VIII. Period of Surveillance:
Surveillance should be ongoing.

IX. Data sharing/release and print criteria:
Notification to CDC of confirmed and probable cases of syphilis is recommended.

De-identified data are provided by jurisdictions to CDC. Jurisdiction-specific case counts are reported weekly in the MMWR. Data are also analyzed and published in the CDC’s annual Sexually Transmitted Disease Surveillance, in STD surveillance updates within the MMWR, and in peer-reviewed publications. Reports and publications are provided to jurisdictions, to other interested parties, and made available on the internet.

X. References


XI. Coordination

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