



## IUSTI–E Scientific Advisory Council

### Topic Report 2016

#### Topic: Syphilis

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#### Epidemiology

The driving force of the increasing prevalence of Syphilis in Europe is the ongoing epidemics in MSMs. There is a very low perception of the potential severity of the disease. Oral transmission is frequent and anal sex is increasingly unprotected. Serosorting, and alternatives such as: rimming, nudging, dipping, insertive anal intercourse without ejaculation are thought to be safe against HIV infection, without thought of the many other infections, such as Syphilis. The only perceived risk is unprotected receptive anal intercourse with ejaculation. Increasing numbers of HIV infected persons are efficiently treated with HAART, Many now achieve undetectable Viral Load with ART, and feel themselves non contagious: true for HIV, but no protection for other infections, especially Syphilis. Chemsex is increasing the risk, and the lack of concern is breathtaking (A.Bourne et al Sex Transm Inf 2015; 91:564-8).

Syphilis is reemerging as a problem in pregnant women, with the potential of transmission of Treponema during the second part of pregnancy, and cases of Congenital Syphilis are occurring, especially in those who have not engaged in antenatal care.

Incidence of Syphilis in Russia (25.0 per 100 000 of population) remains high in comparison with other parts of Europe. The growing number of late cases of syphilis, including cardiovascular and neurosyphilis, is causing alarm.

Recently, increased number of refugees can affect the spread of syphilis and other STIs and their engagement in health care and the cooperation with health authorities of neighboring countries is necessary.

#### Clinical presentations

The primary lesion is frequently unnoticed, and mild forms of non-specific skin lesions are often misdiagnosed, until examined by an experienced dermatovenereologists, and serology performed.

Clinically, ophthalmic syphilis is an early form of neurosyphilis, which can be observed during secondary syphilis, and is increasingly seen as the clinical presentation. It should be treated like late neurosyphilis.

The interpretation of syphilis serology by other specialists, cardiologists, ophthalmologists and neurologists, can be fraught with hazard, and the possible connection of their patient's conditions with late syphilis is underestimated

Information regarding the polymorphism, severity and extent of Syphilis and the need of regular screening is urgently needed to be disseminated

### **Treatment**

The shortage of Long Acting Penicillin G (Benzathine Peni G, BPG) in many European countries is a major concern. This is the best treatment recommended by all guidelines, with more than 90% of success. In some countries, the supply is situation is so critical that BPG has to be ordered from abroad, with consequent delays in initiating treatment

The increasing prescription of doxycycline as an alternative should not be recommended. So far, no case of *T. pallidum* resistance to doxycycline has been reported, but the treatment is inferior to BPG, and there is a high risk of poor compliance. Moreover, in the PrEP field, doxycycline has been proposed as prophylaxis in continuous suppressive treatment (R. Bolan et al Sex Transm Dis 2015; 42: 98-103) or intermittent prophylaxis (ANRS trial Ipergay) with the potential risk of uncured syphilis.

In the future, we most try to improve the follow-up of patients after treatment, as most studies show that more than 70% of patients are lost after having received treatment for syphilis. This is crucial as most reinfections are asymptomatic or less symptomatic than the first episode, justifying repeating syphilis serology regularly.

### **5 Most Important Recent Publications**

**TBA**

### **Potential Speakers**

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## **Questions to be answered by future Research**

**TBA**

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