Incidence of infectious syphilis continues to increase in BC

The incidence of infectious syphilis (i.e., primary, secondary, early latent) has increased nearly fivefold from 2010 to 2015 in BC, and is projected to further increase in 2016 (**Figure 1**). Men who have sex with men (MSM) are disproportionately affected by infectious syphilis. In the first half of 2016 over 86% of men diagnosed with syphilis identified as MSM.

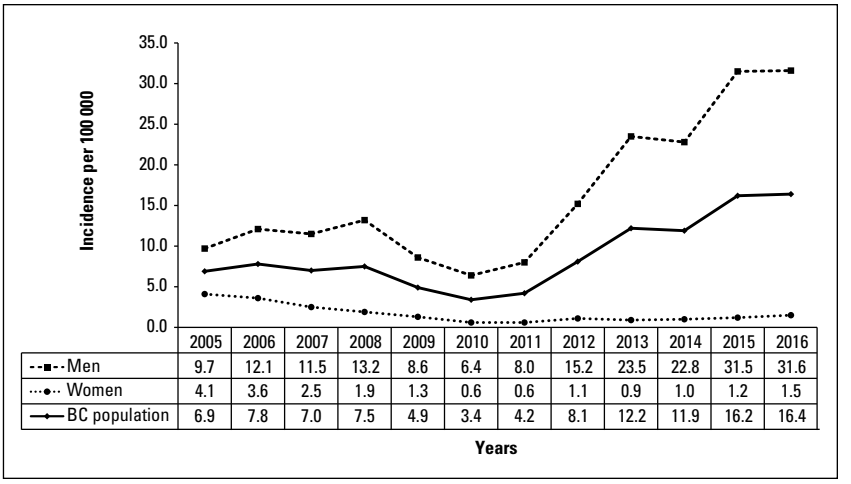
While relatively few cases of infectious syphilis are diagnosed among women, incidence is increasing among women of childbearing age, raising concerns for congenital syphilis. In the United States a 40% increase in congenital syphilis was observed from 2012 to 2014.[1] In the first half of 2016, there were two infectious syphilis cases diagnosed in pregnant women in BC. No congenital syphilis cases have been reported since 2012, likely owing to a strong prenatal screening program.

Syphilis and HIV co-infection is a significant concern, as HIV impacts the clinical manifestations of syphilis[2] and may lead to poorer treatment responses.[3] As well, syphilis can increase the risk of transmission and acquisition of HIV.[4] In BC about 40% of syphilis cases are co-infected with HIV. However, over 80% of co-infected cases had undetectable HIV viral loads (i.e., < 40 copies/mL), suggesting that the risk of HIV transmission is very low.

Counseling patients to use safer sexual practices, such as consistently using condoms, can help prevent the spread of syphilis. Clinicians should consider syphilis as part of their differential diagnosis in all sexually active patients, particularly those presenting with a new lesion or rash. Since syphilis can present without obvious symptoms, routine screening for sexually transmitted infections is recommended. Individuals at higher risk of acquiring syphilis, such as those with multiple sexual partners and those belonging to groups with high rates of syphilis like MSM, should be screened every 3 to 6 months. Among pregnant women syphilis screening should be performed during the first trimester. Screening should be repeated at 28 to 32 weeks and at delivery for women at high risk of syphilis (e.g., those with new sexual partners).[5] The BC Centre for Disease Control (BCCDC) offers testing reminders by text message or e-mail, available at www.smartsexresource.com/get-tested/testing-reminders.

Serology is the primary means to diagnose syphilis. However, with the appropriate transport medium, PCR testing of oral, anal, and genital lesions can also be done. All positive syphilis results (serology or PCR) are reviewed by a physician at BCCDC to help diagnose, stage, and treat syphilis infections. Nurses at the BCCDC follow up with all diagnosed individuals to provide education, arrange treatment and follow-up testing, and discuss partner notification.

Benzathine penicillin G delivered intramuscularly is the preferred treatment; oral doxycycline is an alter-



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Men	9.7	12.1	11.5	13.2	8.6	6.4	8.0	15.2	23.5	22.8	31.5	31.6
Women	4.1	3.6	2.5	1.9	1.3	0.6	0.6	1.1	0.9	1.0	1.2	1.5
BC population	6.9	7.8	7.0	7.5	4.9	3.4	4.2	8.1	12.2	11.9	16.2	16.4

Figure 1. Incidence of infectious syphilis diagnoses by gender in BC, 2005–16.

*Annual incidence of infectious syphilis in 2016 was estimated based on data collected between January and June 2016.

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native in case of penicillin allergy. Sexual partners exposed in the past 3 months should be tested and treated, as it can take up to 3 months before syphilis can be diagnosed by serology.[6]

For further information about syphilis screening or treatment, contact the BCCDC public health nurse at 604 707-5607 or physician at 604 707-5610.

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Continued from page 439

the College, other stakeholders, and patients all have a role to play, and as partners in health care, together we can make a difference. For doctors, the health and safety of our patients is of utmost importance. We must do everything in our power as a profession to help support and protect our patients—most of whom are often unknowingly vulnerable—by eliminating the judicious overprescribing of opioids. I ask you all, please talk and engage openly with your patients about the opioid crisis we are facing. I also encourage you to let me know your thoughts on this topic. E-mail me at president@doctorsofbc.ca, and I will share some of the feedback I receive on my President's Blog. Let's start the conversation.

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