SYPHILIS INFANT BIRTH PLAN

Copy sent to screening team……(date)

TO BE COMPLETED FOR ALL WOMEN/BIRTH PARENTS WITH A SCREEN-POSITIVE SYPHILIS RESULT

Section 1: Antenatal

GUM planning assessment on…… (date) by……(person)……(Clinic/Trust)

Mother's name……Mother's DOB……EDD……

Hospital no……GUM no……NHS no……..

Pregnancy Treatment: If required is this completed Yes ☐/No ☐/In progress ☐

Treatment	Date given	Comments

Infant Risk Category

		Tick box
Assessed by GUM. Past infection with documentation of previous adequate treatment (with appropriate beta-lactam antibiotic)	**No further action**	
Mother adequately treated with appropriate beta-lactam antibiotic during this pregnancy >4 weeks prior to delivery	**Low risk:** infant requires review at delivery, but not treatment at the time of this plan. See clinical management section below	
Mother: • treated <4 weeks before delivery or • treated with non-beta-lactam regimen or • untreated/inadequately treated or inadequately reported	**High risk:** infant requires review and treatment at delivery. See clinical management section below	

On admission in labour, delivery team to:

Take maternal blood sample for syphilis serology on admission ☐

Contact neonatal team following delivery and add birth plan to infant notes ☐

Section 2: Infant Clinical Management at Birth and Follow-up

Initial investigations for infants requiring monitoring:

- Send venous blood for infant syphilis serology (treponemal antibody/RPR/IgM); check with local laboratory about the volume needed. Infant cord blood should not be used.

- Physical examination (see guide on page 3):

    - If normal allow home with 3-month outpatient appointment for follow-up serology. Check delivery blood results when available and assign responsibility for checking results. See infant follow-up testing schedule on page 4.
    - If any lesions or other clinical signs of congenital syphilis present, infant requires actions below.

Infant syphilis serology or clinical features suggestive of congenital syphilis:

- If lesions present consult local GUM and specialist paediatric services. Carry out dark ground microscopy and/or PCR of exudates or body fluids, e.g. nasal discharge . Send throat swab or naso-pharyngeal aspirate for PCR
- Full blood count, blood film, liver function, electrolytes, creatinine, lactate, bone chemistry
- CSF: cells, protein, RPR, treponemal antibody if available
- Urine: test for blood/protein
- X-rays of long bones
- Ophthalmic assessment
- Audiology
- If physical signs present test for other congenital infections: HIV, hepatitis, HSV etc (SCORTCH)
- Report cases of congenital syphilis as a serious incident (SI)

Treatment for congenital syphilis:

If high risk start at birth, no need to wait for serology results

Benzylpenicillin 25 mg/kg IV (BNFc) for 10 days	Neonate up to 7 days of age	12 hourly
	Neonate 7 days to 28 days	8 hourly
	>28 days old	6 hourly

- If ≥24 hour's dosing is missed, treatment must be restarted as Treponema can rapidly regrow
- If CSF white cells/protein raised or RPR positive/TPHA >1:320 treat for 10 days and repeat LP at 6 months

Ceftriaxone - for ambulatory care if unable to admit for 10 days

- 75 mg/kg for <1 year old daily IV or IM for 10 days
- 100 mg/kg ≥1 year old daily IV or IM for 10 days

Follow-up contact:

Name: ……Tel: ……E-mail: ……..

Physical Examination Guide – Signs of Early Congenital Syphilis

Approximately half of all neonates with congenital syphilis are normal on initial examination. Common manifestations are in bold (40–60% will have at least one)

General	**Low birth weight, prematurity,** non-immune hydrops, pyrexia
Haematological	**Generalised lymphadenopathy, hepatosplenomegaly**, jaundice, anaemia (can be haemolytic), thrombocytopenia
Skin	**Rash** (usually maculo-papular, but almost any form of rash is possible, may be a blueberry muffin rash), the palms and soles may be red, mottled and swollen, vesiculobullous lesion, condylomata lata (flat, wart-like plaques in moist areas such as the perineum), perioral fissures, severe desquamation, often of hands/feet
Mucous membranes	**Haemorrhagic rhinitis** (bloody snuffles), ulceration of the nasal mucosa, mucous patches
Neurological	Meningitis, microcephaly, hydocephaly, intracranial calcification, sensorineural deafness, failure to move an extremity (pseudo-paralysis of Parrot)
Ophthalmic	Cataracts, corneal scarring, glaucoma, chorioretinitis, microphthalmia
Skeletal	Osteochondritis, periostitis (elbows, knees, wrists)
Liver	Hepato-splenomegaly, jaundice (may be conjugated), hepatitis
Other	Multi-organ failure, glomerulonephritis, pneumonitis

Infant Follow-up – Testing Schedule

Age	Infant not treated for syphilis	Infant treated for syphilis at birth
3 months	RPR and treponemal IgM • If RPR and IgM negative: discharge • If RPR titre falling but still positive: repeat at 6 months • If RPR titre unchanged from birth or rising or IgM positive: discuss with local paediatric infection specialists or GUM	RPR and treponemal IgM • If RPR falling: review at 6 months • If RPR unchanged from birth or rising or IgM positive: discuss with local paediatric infection specialists or GUM
6 months	RPR • If RPR negative: discharge • If RPR titre falling but still positive: repeat at 12 months • If RPR titre unchanged from previously or rising: discuss with local paediatric infection specialists or consult GUM	RPR • If RPR falling: review at 12 months • If RPR unchanged from previously or rising: discuss with local paediatric infection specialists or GUM Infants treated with a positive CSF should also have follow-up CSF after 6 months
12 months	RPR • If RPR negative: discharge • If RPR positive: discuss with local paediatric infection specialists or GUM	RPR • If RPR has achieved sustained 4X drop from peak level: discharge • If RPR remains higher: discuss with local paediatric infection specialists or GUM

Notification: positive antenatal screening treponemal serology and cases of possible/confirmed congenital syphilis should be notified to the Integrated Screening Outcomes Surveillance Service (ISOSS).