Oregon Perinatal Collaborative

# Coordinated Congenital Syphilis Prevention Guide for Emergency Departments

## OREGON PERINATAL COLLABORATIVE

**Acknowledgements:** The Oregon Perinatal Collaborative (OPC) gratefully acknowledges the multidisciplinary volunteer members, representing clinical and non-clinical expertise, of the Coordinated Congenital Syphilis Prevention Workgroup who helped develop and review the content of this guide, as well as plan for implementation.

**Coordinated Congenital Syphilis Prevention Leadership**

**Silke Akerson**, MPH, CPM, LDM, Oregon Perinatal Collaborative
**Cayenne Buell**, MPH, Oregon Perinatal Collaborative
**Irina Cassimatis**, MD, MSc, Oregon Health & Science University
**Aaron Caughey**, MD, PhD, Oregon Perinatal Collaborative
**Jillian Garai**, MPH, RN, Oregon Health Authority
**Ami Hanna**, MPH, Comagine Health
**Pete Singson**, MD, Oregon Health Authority
**Phillip Wetmore**, Comagine Health

**Coordinated Congenital Syphilis Prevention Workgroup Members**

**Aimee Hughes**, RN, Department of Corrections
**Alba Moraila**, Multnomah County Health Department
**Ali Hayes**, MPH, Clackamas County Public Health
**Amy Marr**, MD, Legacy Emanuel Medical Center
**Anna Saeger**, MPH, CPH, Cascade AIDS Project
**Ashley Allison**, Oregon Aids Education & Training Center
**Basilia Basin**, PhD, RN, OHSU - PATHS
**Bob Danenhoffer**, MD, MPH, Douglas County Public Health
**Caroline Castillo**, MD, Marion County Public Health
**Chris L'Hommedieu**, Legacy Good Samaritan
**Chris Keating**, RN, Washington County Health & Human Services
**Christina Baumann**, MD, MPH, Washington County Health & Human Services
**Cynthia Maree**, MD, St. Charles - Bend
**David Cuevas**, DIS Program Supervisor, Multnomah County Health Department
**Dayna Morrison**, Oregon Aids Education & Training Center
**Diana Smith**, CNM, MPH, Legacy Health
**Hannah Woods**, OHSU-PATHS
**Haven Wheelock**, MPH, Outside In
**Jack Marshall**, MD, OHSU
**Jeffrey Gander**, MBA, BSN, RN ACRN, Clackamas County Public Health
**Karen Relucio**, MD, Department of Corrections
**Kellie Hansen**, RN, Klamath County Health Department
**Ken Bizovi**, MD, Providence
**Kristin Prewitt**, MD, OHSU
**Marsha Brumbaugh**, CDI, Multnomah County Health Department
**Meagan Cundiff**, RN, Legacy Good Samaritan
**Meredith Mance**, RN-BSN, CPM, LDM, IBCLC, Yamhill County Public Health
**Miriam Morehart**, Multnomah County Health Department
**Murray McLachlan**, MD, Legacy Emanuel
**Nicole Sticka**, RN, Lane County Public Health
**Nicole Williams**, Legacy Health
**Opher Nadler**, MD, Oregon College of Emergency Physicians
**Rachel Posnick**, Marion County Public Health
**Richard Bruno**, MD, MPH, Multnomah County Health Department
**Sarah Present**, MD, MPH, Clackamas County Public Health
**Sarah Bovee**, Doula, THW, CRM, PWS, CrMA, Legacy Health
**Sophie Grant**, RN, Lane County Public Health
**Stephen Kane**, MD, Multnomah County Corrections Health
**Teresa Everson**, MD, MPH, Multnomah County Health Department
**Wahji Kasten**, ND, MPH, Central City Concern
**YoungYoon Ham**, PharmD, OHSU

**Suggested Citation (V#, Month Day, Year):**

Oregon Perinatal Collaborative (Year). Oregon Perinatal Collaborative Coordinated Congenital Syphilis Prevention Guides.

# Table of Contents

## Purpose and Background

Oregon is experiencing a congenital syphilis emergency. Although overall syphilis rates in Oregon have recently decreased, syphilis diagnosed during pregnancy remains a persistent problem, resulting in more infants affected by this preventable disease. As of 2024, the state's congenital syphilis rate increased 2,150% over the past decade, with cases reported across 25 counties over that period (Singson, 2025). Congenital syphilis occurs when untreated infection in the pregnant individual is transmitted to the fetus and can result in miscarriage, prematurity, low birth weight, congenital anomalies, stillbirth and infant death; up to 70% of untreated infections lead to adverse pregnancy outcomes (Duan et al, 2025).

This burden is particularly striking given that congenital syphilis is preventable with timely screening and treatment. All pregnant people should be screened **at least** three times during pregnancy (at first encounter, at 28 weeks, and at delivery) (ACOG, 2024); however, many individuals at highest risk receive limited or no prenatal care and are not screened or treated. According to Oregon's Public Health Epidemiologists' User System's 2025 data, 76% of pregnant people associated with a congenital syphilis case had no prenatal care or initiated care within 30 days of delivery (OHA, 2025). Notably, many of these patients had contact with the healthcare system, specifically in emergency departments or community settings, but were not screened. The burden of syphilis also disproportionately affects pregnant people of color, those experiencing housing instability, carceral system involvement, substance use, and/or have a history of sexually transmitted infections.

Emergency departments are critical access points for care and represent key partners in improving screening, treatment, and referral. Increased, cross-setting screening and timely treatment are urgently needed to prevent congenital syphilis in Oregon.

### References


1. American College of Obstetricians and Gynecologists. Practice advisory: screening for syphilis in pregnancy. Published April 2024. Accessed March 5, 2025.
2. Duan B, Zhou Y, Wang X, et al. Congenital syphilis: adverse pregnancy outcomes and neonatal disorders. *Infection*. 2025;53(6):2303-2319.
3. Singson P. Congenital Syphilis Crisis in Oregon [memorandum]. Oregon Health Authority, Public Health Division. Published February 25, 2025. Accessed April 6, 2026.
4. Oregon Health Authority. (2025). Orpheus: Oregon Public Health Epidemiologists' User System. State of Oregon


### Key Resources

Clinical Interpretation of Syphilis Screening Algorithms

CDC 2021 Sexually Transmitted Infection Treatment Guidelines

University of Washington's National STD Curriculum

## Best practices for emergency departments to prevent congenital syphilis

This guide presents **best practices. As capacity varies across emergency departments, sites should implement what is feasible and expand over time as able. Each incremental step toward more complete screening reduces missed cases of congenital syphilis.**

1. Perform **verbal pregnancy screening** for all pregnancy capable people presenting in the emergency department.
2. Perform syphilis screening for any pregnant person without a visible screening result in the medical record:
3. Make efforts to obtain and document reliable contact information for patients who may not have an address, phone or email.
4. Coordinate with County Health Department for follow up on all positive syphilis results in pregnant people.
5. If point-of-care (POC) testing is available, provide treatment to any pregnant individual with a positive POC syphilis test, even if confirmatory serologic testing is pending.

## Benefits of screening in emergency departments

Emergency departments are a critical, and often the only, access point for patients at highest risk for syphilis, including those experiencing housing instability or substance use disorders. Screening in the emergency department reaches people who are missed by traditional healthcare settings.

The benefits extend beyond syphilis: emergency department screening increases diagnosis of other asymptomatic sexually transmitted infections and, most importantly, creates opportunities to prevent congenital syphilis in pregnant patients who would not otherwise be identified.

The impact can be substantial. In Miami-Dade County, enhanced routine emergency department screening generated over 4,800 syphilis tests, identifying 59 confirmed cases and preventing an estimated 9 cases of congenital syphilis (Larios Venegas, 2020).

## Establishing lines of communication between emergency departments and local public health authorities

- **All positive results should be reported to the local public health authority (LPHA) to arrange appropriate follow-up and treatment.** For any pregnant patient with a positive confirmatory serologic testing syphilis result, the hospital lab should have automated reporting to the LPHA, so that the LPHA can arrange appropriate follow-up and treatment.
- **Consider assigning positive results to a specific pharmacy team, if resources allow.** Pharmacists can help ensure timely treatment, flag patients who left without treatment, facilitate referrals, and coordinate with the LPHA for follow-up.
- **Train emergency department staff on syphilis and sexually transmitted infection screening.** All frontline staff (nurses, medical assistants, and providers) should receive education on syphilis screening indications, treatment urgency in pregnancy, and when and how to notify the LPHA.

## Screening and Referral Workflows

1. **Verbal pregnancy screening.** Ask all pregnancy-capable patients presenting to the emergency department whether they are currently pregnant. Perform urine pregnancy test if verbal screen is positive
2. **Social risk assessment.** For all pregnant patients, assess whether the patient has housing instability, a substance use disorder, or lacks prenatal care. For patients with housing instability, substance use disorder, or no prenatal care, also:
    a. Refer to peer support and/or community resources
    b. Obtain reliable contact information *(see Obtaining Reliable Contact Information)*
    c. Prioritize pregnant clients or all pregnancy-capable clients who are disconnected from routine preventive health care and do not have a primary care provider (PCP) or established prenatal care
3. **Syphilis screening.** For all pregnant patients, perform syphilis screening if no result is visible in the medical record for this pregnancy. A negative screen returns the patient to routine emergency department care.
    a. If social risk factors are present and POC syphilis testing is available at the site, prioritize POC testing to enable presumptive treatment at the same visit.
4. **Positive POC syphilis tests, next steps.** For all positive POC tests (regardless of risk factors):
    a. Provide presumptive treatment
    b. Obtain confirmatory serologic lab testing
    c. Obtain reliable contact information *(see Obtaining Reliable Contact Information)*
    d. Report to the local public health authority. POC results are often not transmitted to the LPHA through the hospital electronic laboratory reporting. Sites should confirm whether automated reporting exists for POC tests through their lab and, if it does not, report positives directly via the Confidential Oregon Online Reporting Form.
5. **Offer partner presumptive treatment:** If the patient's partner is present and can be physically evaluated, offer presumptive treatment for syphilis exposure. Treating the partner reduces the risk of maternal reinfection during pregnancy. *Note: this is not expedited partner therapy (EPT), which is not recommended for syphilis.*

## Point-of-Care Syphilis (POC) Tests

Currently available syphilis POC tests are treponemal-only, meaning they cannot distinguish between an active infection and a previously treated one. A positive result is presumptive and requires confirmatory lab-based serology testing. However, for a client with no known history of syphilis, a positive POC test is sufficient to initiate treatment without waiting for confirmatory results.

### When POC tests are most useful

The biggest advantage of POC tests is same-day results, which enable same-day treatment and counseling. This is especially valuable for individuals who are unlikely to return for results, including those with housing instability, substance use disorder, short-term incarceration, and those lacking prenatal care. In these situations, a POC test may be the only realistic opportunity to screen and treat.

Lab-based testing remains preferable when individuals have reliable healthcare access and are likely to follow up, or in settings where the patient will be present long enough that rapid results are not needed.

## Reporting positive POC test results to the local public health authority

Unlike lab-based tests, POC test results **may not be** automatically transmitted to LPHA through Electronic Lab Reporting. **Please confirm with your laboratory.** A positive POC test must be reported directly by the provider or organization performing the test by using the Confidential Oregon Online Reporting Form or phone call

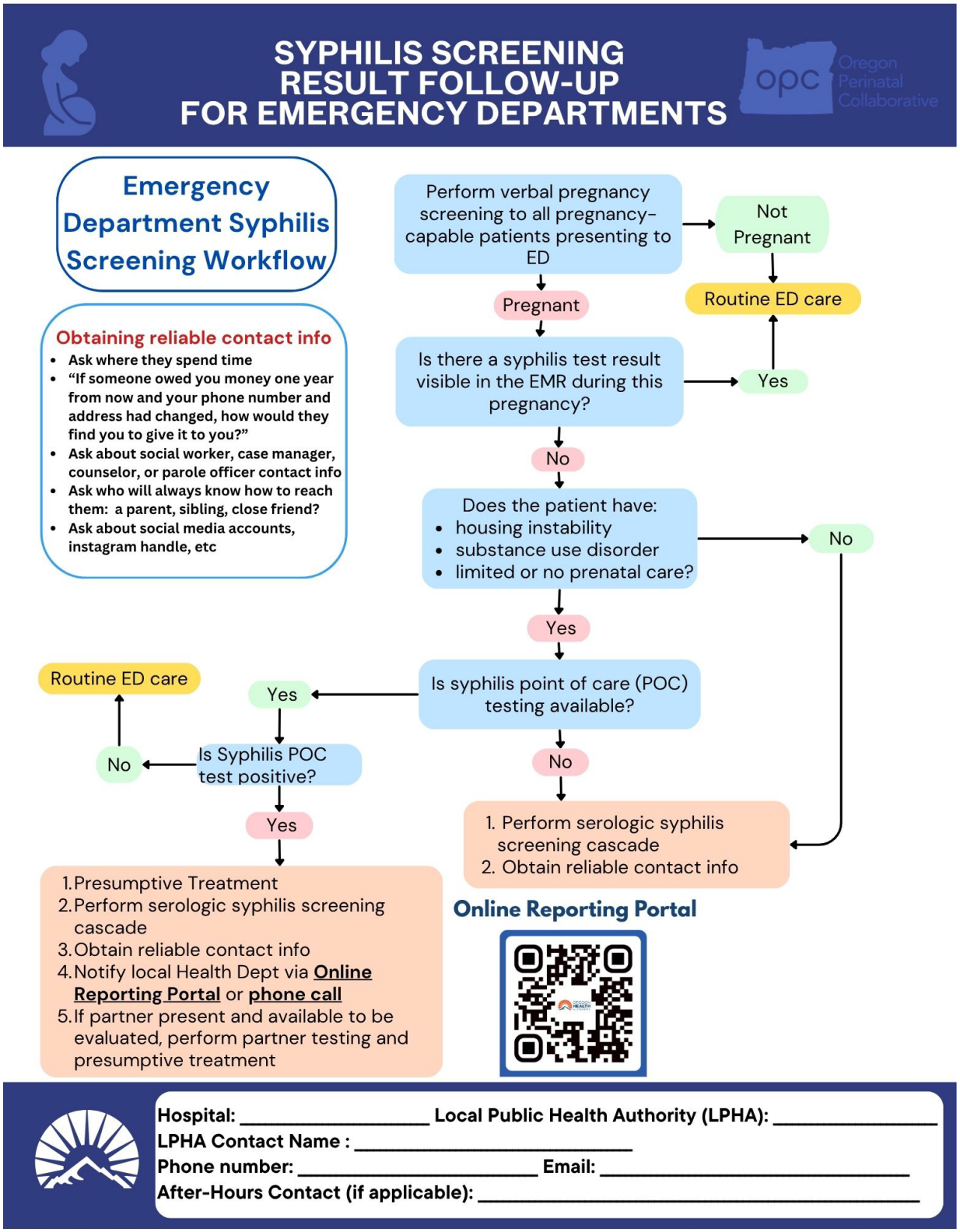
**Do not assume the local public health authority has been notified, report all positive results promptly.**

**Key points to communicate to patients with a positive result:**

- A positive test does not necessarily mean active infection; confirmatory testing is needed
- If there is no known history of syphilis (patient reported or visible in the electronic medical record), a positive POC test is generally enough to initiate treatment
- Follow-up with a clinical provider is essential

*POC tests may produce false negatives or false positives. A negative result in a high-risk pregnant client should not preclude referral for lab-based serology testing if there is clinical concern.*

***Syphilis Screening Algorithm Poster**: This poster includes fields for local public health authority (LPHA) contact information. Emergency departments may print and display in clinical areas, supporting timely follow-up and reporting.*



## Syphilis Screening Algorithm and Interpretation

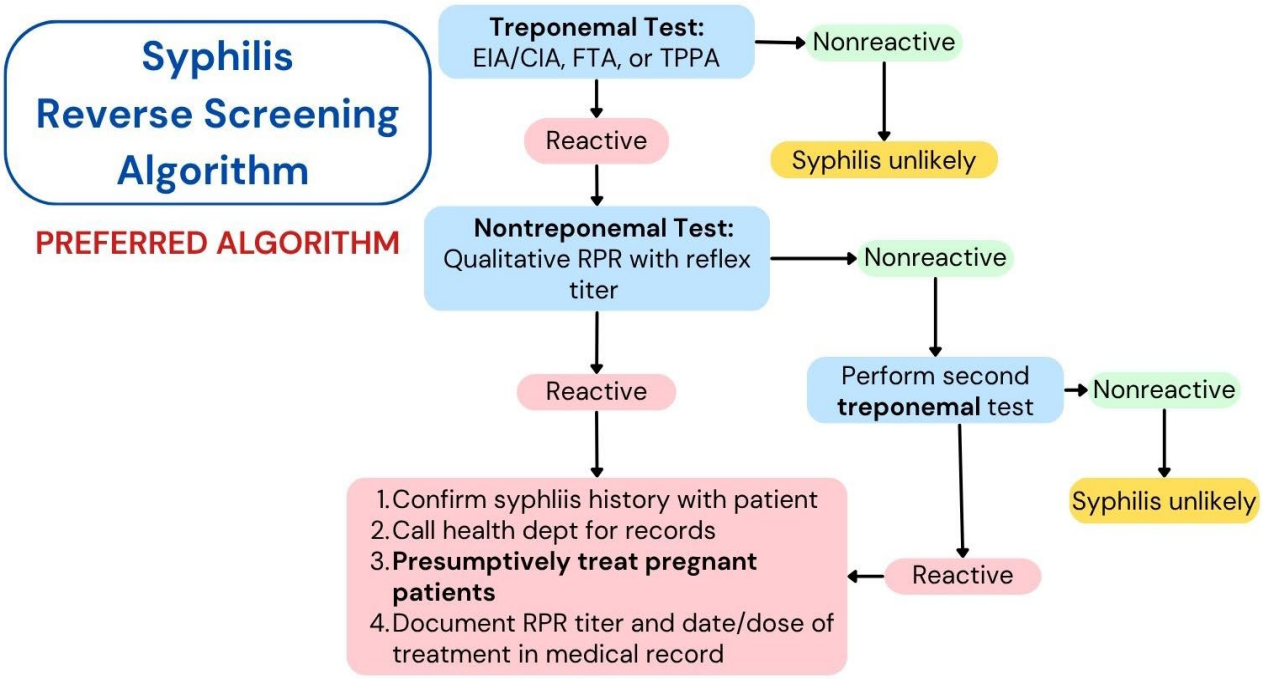
Syphilis serology relies on two distinct antibody types, each with important limitations.

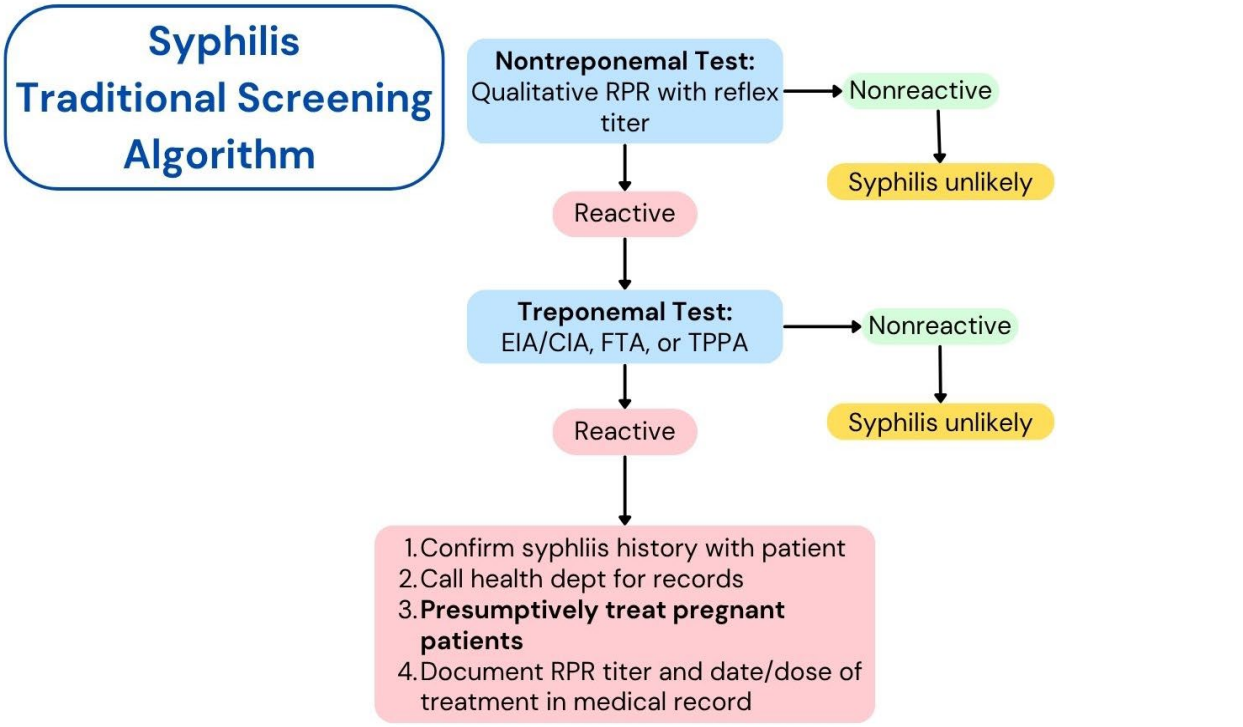
**Non-treponemal tests (RPR, VDRL)** detect nonspecific antibodies to host cell antigens and may be undetectable in early or late/latent infection. Titers decline after successful treatment, making them useful for monitoring. These antibodies are not specific to syphilis and can cause biological false positives. Results should be correlated with the patient's history and presentation.

**Treponemal tests (TPPA, FTA, EIA, CIA)** detect *T. pallidum*-specific antibodies. They become positive earlier in infection but remain positive for life regardless of treatment. Treponemal tests may produce false positives. Results should be correlated with the patient's history and presentation.

**Why the algorithm changed:** The traditional approach (non-treponemal testing first) misses up to 40% of latent syphilis cases due to non-reactive RPR/VDRL. The reverse algorithm (treponemal test first, reflex RPR/VDRL if positive) improves sensitivity for latent disease and is better suited to current laboratory technology.

***Syphilis Screening Cascade: Reverse algorithm is preferred***



## Screening Challenges and Loss to Follow Up

1. **Screening in limited-privacy settings**
   ED crowding and boarding mean that sensitive screening conversations often happen in triage or shared spaces. A few strategies:
   - **Use opt-out language.** Frame syphilis screening as a routine part of pregnancy care, "we screen all pregnant patients for syphilis" rather than a risk-based ask. This reduces stigma and improves uptake.
   - **Address concerns about incarceration, warrants, or Department of Human Services involvement.** Some patients will decline screening out of fear of legal or child welfare consequences. Reassure patients that a positive result triggers a public health, not a law enforcement response, and that your role is to provide care, not to report to Department of Human Services or police. Know your institution's specific confidentiality policies so you can speak to them accurately.
   - **Counsel patients about test nuances.** Briefly explain that a positive initial screen requires confirmatory testing before a diagnosis is made, and that false positives occur. This reduces anxiety and improves willingness to screen and follow up.

2. **Preventing loss to follow-up**
   - **Know how positive results are reported:** Labs are reported to the county of residence on file, **not the county where the emergency department is located.** Confirm the patient's actual current county of residence, which may differ from any address in the chart.
   - **Collect usable location information:** If a street address is not available, document where the patient is staying, a shelter name, a description of a camping location, a neighborhood; anything that could support outreach if needed.
   - **Collect alternate contact information:** For patients without a phone or stable address, see the contact guide for additional strategies, including social media handles, guarantee contacts, and service locations the patient visits regularly (such as a syringe service program or shelter).
   - **Consider creation of an EHR smart phrase for accurate location information:** For patients experiencing houselessness or housing instability, a dot phrase can prompt providers to systematically capture information useful for CHD outreach—even when a street address is unavailable. The dot phrase should prompt documentation of:
     a. Best contact number or callback time
     b. Cross streets or nearest intersection
     c. Nearby landmarks (e.g., specific park, overpass, building)
     d. Organizations the patient is connected to (e.g., shelter name, service program, day center)
   - **Refer to peer support:** all pregnant people not receiving prenatal care, experiencing housing instability, or substance use disorder risk factors should be referred to peer support and/or other resources.

**Obtaining Reliable Contact Information**

For patients without a stable address or phone number, ask:

- **Social media:** Facebook Messenger name, Instagram handle, or other platform
- **Guarantee contacts:** "Who will always know how to reach you?"
  - Collect name + phone for up to 2–3 people (parent, sibling, close friend)
- **Social services:** social worker, case manager, counselor, or parole officer
  - Collect agency name and contact info with patient permission
- **Where they spend time:** shelters, encampments, service locations, or community spaces that could support in-person outreach
- **The money question** "If someone owed you money one year from now and your number and address changed, how would they find you?"

1. **Presumptive partner treatment**
   - Offer presumptive treatment to partners of pregnant individuals with a positive POC test or serologic syphilis cascade who present to the emergency department. *Note: this is not EPT, which is not recommended for syphilis.*

2. **Provider Liability**
   - ED providers may hesitate to screen out of concern that a positive result creates follow-up obligations that lead to provider liability. Failure to screen when indicated may carry greater liability risk. **Documenting reliable contact information and that patients were counseled about the importance of follow-up in the electronic medical record is recommended.**

## Treatment Recommendations and Considerations

**Benzathine penicillin G (Bicillin L-A) is the only antibiotic approved for use in pregnancy.** A national shortage is ongoing following a Pfizer recall.

- Confirm local stock before assuming availability. Non-pregnant patients should receive doxycycline for primary/secondary syphilis; pregnant patients must be desensitized and treated with Benzathine penicillin G.
- Pregnant patients with reported true penicillin allergy must be desensitized and treated with benzathine penicillin G. Refer urgently to Allergy/Immunology or Infectious Disease.
- **Treat at the same visit as diagnosis**: Do not defer for consultation or confirmation unless there is a specific clinical reason. Same-visit treatment is the standard of care.
- **Jarisch-Herxheimer reaction** may occur within 2-8 hours of treatment: fever, rigors, myalgia, headache, and uterine contractions. Counsel patients before treatment. This is not an allergic reaction. Fetal monitoring may be warranted if the patient develops contractions in the third trimester.
- **Document completely:** Date, drug, dose, route, lot number, injection site, administering provider, and patient tolerance.

***Syphilis treatment recommendations for pregnancy-capable and pregnant individuals, based on presumed stage at time of diagnosis***

| Stage | Preferred Regimen | Alternative |
|---|---|---|
| Primary, Secondary, or Early Latent (< 12 months) | **Benzathine penicillin G 2.4 million units IM x 1 dose**<br>*(Bicillin L-A or approved imported equivalent)** | Doxycycline 100 mg PO BID x 14 days<br>**CONTRAINDICATED IN PREGNANCY** |
| Late Latent or Unknown Duration (>= 12 months or unknown) | **Benzathine penicillin G 2.4 million units IM x 3 doses**<br>*(Bicillin L-A or approved imported equivalent)**<br>• Once weekly x 3 weeks<br>• Entire course must be restarted if > 9 days elapsed between doses | Doxycycline 100 mg PO BID x 28 days<br>**CONTRAINDICATED IN PREGNANCY** |
| Penicillin allergy, pregnant | Mandatory penicillin desensitization, then Benzathine penicillin G per stage<br>• Refer to Allergy/ID for desensitization urgently | No acceptable alternative during pregnancy -- desensitization is required and should be performed by Allergy/ID specialist |
| Sexual partner(s) -- presumptive treatment | **Benzathine penicillin G 2.4 million units IM x 1 dose**<br>*(Bicillin L-A or approved imported equivalent)**<br>• Test concurrently | Doxycycline 100 mg PO BID x 14 days<br>• Bicillin is preferred when available. Doxycycline non-adherence is common and risks maternal reinfection during pregnancy |
| *For pregnancy-capable patients: To address *Bicillin L-A* shortage, the FDA has temporarily authorized two foreign-manufactured Bicillin L-A alternatives for import, Lentocilin (benzathine benzylpenicillin tetrahydrate) and Extencilline (benzathine benzylpenicillin). | | |

## Presumptive Partner Treatment

**Offer presumptive treatment to partners who are present and can be physically evaluated.**

If the patient's partner/s is/are present and can be evaluated, offer them testing and immediate presumptive treatment regardless of test results. The presumptive treatment of partners is critically important to prevent disease progression and reinfection.

**Bicillin is recommended when available for presumptive partner treatment of a pregnant individual, as doxycycline non-adherence is common and risks maternal reinfection during pregnancy.**

**Presumptive partner treatment is not the same as expedited partner therapy (EPT).** EPT—in which medication is given to the index patient to deliver to their partner without the partner being seen by a provider—is not recommended by CDC for syphilis and is not endorsed by any state, including Oregon. For EPT guidance specific to chlamydia and gonorrhea, visit Oregon.gov/OHA

## Addressing Practical Barriers to Treatment Completion

For unhoused patients or those with active substance use disorder completing treatment requires addressing logistics:

- **Temporary housing:** Patients may need bridge housing during or after treatment. Engage emergency department social worker or LPHA to facilitate hotel/shelter placement.
- **Safety during housing placement:** Discharge all patients with naloxone (if they have opioid use disorder) and harm reduction counseling; connect to peer support where available.
- **Transportation and phones:** Coordinate with social work to offer ride vouchers or Medicaid transport for follow-up visits. For patients without a phone, inquire about additional forms of contact

# Appendix

## References

1. Larios Venegas, A., Melbourne, H. M., Castillo, I. A., Spell, K., Duquette, W., Villamizar, K., Gallo, G., Parris, D., & Rojas, L. M. (2020). Enhancing the Routine Screening Infrastructure to Address a Syphilis Epidemic in Miami-Dade County. Sexually transmitted diseases, 47(5S Suppl 1), S61–S65.

## Resources

- Clinical Interpretation of Syphilis Screening Algorithms
- BRIDGE Emergency Department Screening & Treatment for Syphilis Clinical Protocol
- CDC Syphilis Treatment Guidelines
- Oregon Online Reporting Form (for positive syphilis POC tests)

## Other considerations

- Incentivizing screening
- Role of peers, CHW, mobile units
- Support referrals to Project Nurture/Nurture Oregon BEFORE patient presents at hospital for delivery
- Housing support (long term)

# SYPHILIS SCREENING RESULT FOLLOW-UP FOR EMERGENCY DEPARTMENTS

Oregon Perinatal Collaborative

## Emergency Department Syphilis Screening Workflow

Perform verbal pregnancy screening to all pregnancy-capable patients presenting to ED

- Not Pregnant → Routine ED care
- Pregnant → Is there a syphilis test result visible in the EMR during this pregnancy?
  - Yes → Routine ED care
  - No → Does the patient have:
    - housing instability
    - substance use disorder
    - limited or no prenatal care?
      - No → 1. Perform serologic syphilis screening cascade 2. Obtain reliable contact info
      - Yes → Is syphilis point of care (POC) testing available?
        - No → 1. Perform serologic syphilis screening cascade 2. Obtain reliable contact info
        - Yes → Is Syphilis POC test positive?
          - No → Routine ED care
          - Yes → 1. Presumptive Treatment 2. Perform serologic syphilis screening cascade 3. Obtain reliable contact info 4. Notify local Health Dept via **Online Reporting Portal** or **phone call** 5. If partner present and available to be evaluated, perform partner testing and presumptive treatment

### Obtaining reliable contact info

- **Ask where they spend time**
- **"If someone owed you money one year from now and your phone number and address had changed, how would they find you to give it to you?"**
- **Ask about social worker, case manager, counselor, or parole officer contact info**
- **Ask who will always know how to reach them: a parent, sibling, close friend?**
- **Ask about social media accounts, instagram handle, etc**

### Online Reporting Portal

**Hospital:** _____ **Local Public Health Authority (LPHA):** _____

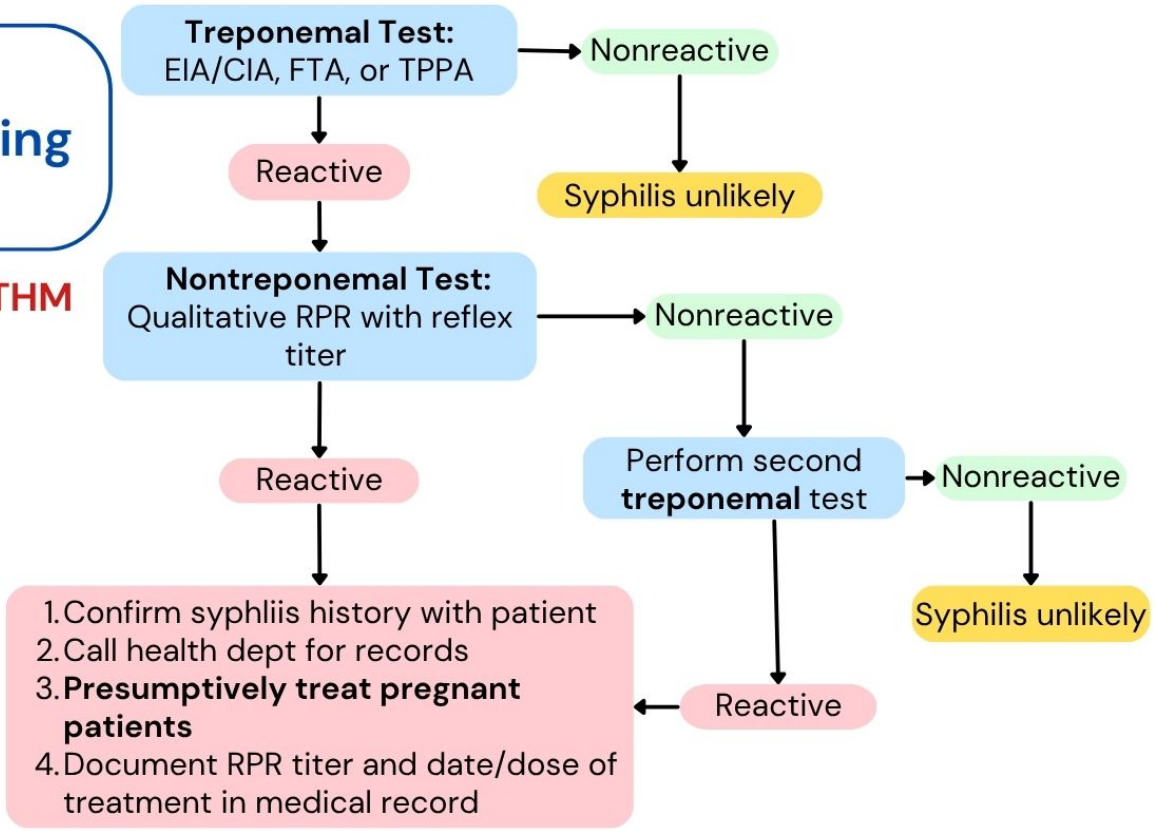
**LPHA Contact Name :** _____

**Phone number:** _____ **Email:** _____

**After-Hours Contact (if applicable):** _____

## Syphilis Reverse Screening Algorithm

**PREFERRED ALGORITHM**




---

## Syphilis Traditional Screening Algorithm