Congenital Syphilis
Investigative Guidelines
September 2026

1. DISEASE REPORTING

1.1 Purpose of Reporting and Surveillance

1. Identify cases of syphilis in pregnancy and prevent vertical transmission
2. Ensure adequate treatment and follow-up for pregnant people with syphilis and the infant
3. Ensure appropriate management, including screening and presumptive treatment, of sexual contacts of pregnant people with syphilis
4. Describe the epidemiology of congenital syphilis in Oregon

1.2 Laboratory and Physician Reporting Requirements

1. Licensed laboratories must report all positive test results indicating syphilis infection to the Local Public Health Authority within one working day (OAR 333-018-0000; 333-018-0015)[1]
2. Clinicians must report lab-confirmed and clinically suspect cases of syphilis to the Local Public Health Authority within one working day (OAR 333-018-0000; 333-018-0015)[1]
   - Oregon Revised Statute (ORS) 433.017 requires individuals attending a pregnant patient to collect or order the collection of a blood specimen for submission to a licensed laboratory to test for syphilis and selected other infections, unless the pregnant patient declines testing (OAR 333-019-0036)[2,3]
   - Oregon Health Authority recommends that all pregnant people be tested for syphilis three times: 1) at the first prenatal visit or presentation to care, 2) at 28 weeks' gestation, and 3) at delivery
3. Health care providers, health care facilities, and licensed laboratories shall cooperate with public health authorities in the investigation and control of syphilis infections (OAR 333-019-0002)[3]

1.3 Local Public Health Authority Reporting and Follow-up Responsibilities

1. LPHA must begin follow-up case investigation within two working days of receiving the initial provider or laboratory report
2. LPHA must report all congenital syphilis cases (including syphilitic stillbirths) to the OHA STD Program through the Oregon Public Health Epidemiology User System (Orpheus) by the end of the calendar week of initial provider or laboratory report (OAR 333-018-0020)[1]

3. LPHA must conduct case investigations and manage sexual contacts by following procedures outlined in these Investigative Guidelines (ORS 433.006, OAR 333-019-0000)[2,3]

2. THE DISEASE AND ITS EPIDEMIOLOGY

2.1 Etiologic Agent

The etiologic agent in syphilis is Treponema pallidum subspecies pallidum, a spirochete (corkscrew-shaped) bacterium.

Of all the subspecies of *T. pallidum*, only *T. pallidum* subsp*. pallidum* is transmitted routinely by sexual contact. The other *T. pallidum* subspecies are transmitted non-sexually (e.g., yaws, pinta).

2.2 Description of Illness

An infection of a stillbirth, infant or child <2 years old, or older child with *T. pallidum* contracted via transplacental transmission or, more rarely, exposure to genital lesions during birth. Congenital syphilis is commonly asymptomatic but may present with early or late signs and symptoms which are often non-specific.

2.3 Reservoirs

Humans

2.4 Modes of Transmission

- Primarily occurs via transplacental passage of *T*. *pallidum* during any stage of syphilis
- More rarely, can also occur on contact with genital lesions during birth

2.5 Incubation Period

Symptoms of congenital syphilis may not appear until several weeks or months after birth and, in some cases, may take years to appear. Early congenital syphilis typically manifests within the first 3 months of life. In late congenital syphilis, symptoms do not usually become apparent until two to five years of age.

2.6 Period of Communicability

Congenital syphilis risk is related to the syphilis stage during pregnancy, with the highest risk occurring during the primary and secondary stages:

- Untreated primary or secondary syphilis in pregnancy results in a 25% risk of stillbirth, a 14% risk of neonatal death, a 41% risk of a live infant with congenital syphilis, and a 20% chance of a non-infected infant
- Untreated late syphilis in pregnancy results in a 12% risk of stillbirth, a 9% risk of neonatal death, a 2% risk of giving birth to an infant with congenital syphilis, and a 77% chance of a non-infected infant[4]

3. CASE DEFINITIONS—FOR PUBLIC HEALTH STAFF

Public health staff determine whether the congenital syphilis surveillance case definition is met. Clinicians consult appropriate guidelines and use clinical judgement in evaluating and treating infants of people with syphilis in pregnancy. The CDC clinical scenarios (§4) do not perfectly align with the CDC congenital syphilis surveillance case definition.

3.1 Congenital Syphilis

See the CDC 2026 Syphilis Surveillance Case Definition page for further information on congenital syphilis case criteria and diagnosis.[5]

Given the complexity of the syphilis surveillance case definition, public health professionals are strongly encouraged to use the CDC Congenital Syphilis Surveillance Case Assessment Navigator (see Appendix A) instead of or alongside this section to determine whether the congenital syphilis surveillance case definition is met. The information in this section and the flowcharts is identical, but the flowcharts are much easier to follow.

3.1.1 Congenital Syphilis

1. Clinical Description
   - **Early Congenital Syphilis (infant or child <2 years old):** Manifestations can include rhinitis (“snuffles”), osteochondritis or periostitis, enlarged liver and spleen, nonimmune hydrops or edema, conjugated or direct hyperbilirubinemia, cholestatic jaundice, skin rashes, or nonspecific signs/symptoms
   - **Late Congenital Syphilis (child ≥2 years old):** Manifestations can include saddle nose, tibial thickening (“saber shins”), joint swelling (“Clutton joints”), perforation of hard palate, abnormal tooth development (“Hutchinson teeth” or “mulberry molars”), corneal inflammation, or brain and nerve problems causing blindness and deafness
   - **Syphilitic Stillbirth:** Fetal death that occurs at or after a 20-week gestation or in which the fetus weighs ≥350 grams and the birthing person had untreated or inadequately treated syphilis at delivery
     - Inadequate treatment consists of any nonpenicillin therapy; penicillin therapy initiated <30 days before delivery; incomplete therapy or dosing intervals outside of 6-9 days for treatment of late/unknown duration syphilis
2. Laboratory Criteria
   - Confirmatory: Meets at least one of the following criteria in an appropriate specimen:
     - Direct detection of *T. pallidum* by darkfield microscopy in a specimen that was both not obtained from the throat and not potentially contaminated by stool **OR**
     - Direct detection of *T. pallidum* by immunohistochemistry (IHC) staining in a specimen that was both not obtained from the oropharynx and not potentially contaminated by stool **OR**

    - Direct detection of *T. pallidum* by nucleic acid amplification test (NAAT) or a diagnostically equivalent molecular method in any specimen
  - Presumptive
    - A current (performed in the context of this clinical evaluation) reactive blood-based nontreponemal antibody test collected from an infant or child
  - Supportive Laboratory/Radiographic Evidence: Meets at least one of the following criteria in an infant or child, with no other identifiable causes for these abnormalities:
    - In a lumbar puncture without visibly blood-contaminated CSF (defined as CSF red blood cell count of ≥500 RBCs/μL or, in the absence of a CSF RBC count, CSF described as bloody in appearance), a reactive CSF VDRL test or an elevated CSF white blood cell (WBC) count **OR**
    - A blood-based nontreponemal antibody test titer at least fourfold higher than the maternal blood-based nontreponemal antibody test titer in specimens collected within 7 days of birth **OR**
    - Evidence on radiographs of long bone abnormalities consistent with congenital syphilis
3. Epidemiologic Linkage Criteria
  - A stillborn infant, liveborn infant, or child born to a person with untreated or inadequately treated syphilis at delivery
    - Inadequate treatment in pregnancy is anything other than completion of a recommended regimen, in accordance with CDC STI Treatment Guidelines or equivalent CDC clinical management guidelines, initiated 30 or more days before delivery.
    - Inadequate treatment for a non-pregnant person with childbearing capacity is any treatment given that differs from the recommended or alternative treatments listed in the CDC STI Treatment Guidelines or equivalent CDC clinical management guidelines.
4. Vital Records Criteria
  - A fetal death in which syphilis is specified on the Report of Fetal Death as the cause of, or a condition contributing to, fetal death
5. Case Classification
  - **Confirmed:**
    - A liveborn infant or child who meets confirmatory laboratory evidence AND the suspected or most likely source of infection is *in utero* **OR**
    - A fetal death that occurs at or after a 20-week gestation or in which the fetus weighs ≥350 g AND meets confirmatory laboratory evidence
  - **Presumptive:**
    - A liveborn infant or child born to a person with untreated or inadequately treated syphilis at delivery **OR**

- A liveborn infant or child who meets presumptive laboratory evidence AND the suspected or most likely source of infection is *in utero* AND meets either clinical criteria or supportive laboratory/radiographic evidence **OR**
- A fetal death that occurs at or after a 20-week gestation or in which the fetus weighs ≥350 g AND either is born to a person with untreated or inadequately treated syphilis at delivery or meets vital records criteria

4. CLINICAL MANAGEMENT—FOR MEDICAL PROVIDERS

The information in this section is adapted from the CDC 2021 STI Treatment Guidelines, which outline infant evaluation and treatment based on specific clinical scenarios.[6]

When a baby is born to a person with syphilis, the priority is to determine which clinical scenario applies. Clinicians consult appropriate guidelines and use clinical judgement in evaluating and treating infants of people with syphilis in pregnancy. Public health staff determine whether the congenital syphilis surveillance case definition is met (§3.2). The CDC clinical scenarios do not perfectly align with the CDC congenital syphilis surveillance case definition.

Serologic RPR testing should be performed on the infant's serum. Umbilical cord blood can become contaminated with maternal blood and yield a false-positive result and Wharton's jelly within the umbilical cord can yield a false-negative result.

Treponemal testing on the infant's serum is not recommended because it is difficult to interpret, as passively transferred maternal antibodies can persist for >15 months.

4.1 Management of Infants Aged <1 Month

Infants exposed to syphilis in utero should be examined for signs of congenital syphilis. Pathologic examination of the placenta or umbilical cord using IHC staining or PCR testing should be considered, including in cases of stillbirth.

Diagnosis of congenital syphilis can be difficult. Maternal nontreponemal and treponemal antibodies can be transferred through the placenta to the fetus, complicating the interpretation of reactive serologic tests for infants. Treatment decisions frequently must be made based on identification of maternal syphilis; adequacy of maternal treatment; clinical, laboratory, or radiographic evidence of syphilis in the infant; and comparison of maternal and infant titers at birth.

4.1.1 Infant Evaluation and Treatment: if maternal reactive RPR and treponemal tests in pregnancy and reactive RPR at delivery (including for cases diagnosed at delivery)

The OHA/AETC Congenital Syphilis Evaluation and Treatment Pocket Guide (see Appendix B) is a helpful flowchart for determining which clinical scenario below applies if the birthing person had reactive nontreponemal and treponemal

antibody tests in pregnancy and a reactive nontreponemal antibody test at delivery (including for cases diagnosed at delivery).

Scenario 1: Confirmed Proven or Highly Likely Congenital Syphilis

Infant with:

- Abnormal physical exam consistent with congenital syphilis **OR**
- RPR titer that is fourfold or greater higher than the maternal titer at delivery **OR**
- Positive darkfield test or PCR of placenta, cord, lesions or body fluids or a positive silver stain of the placenta or cord

Recommended Evaluation:

- CSF analysis for VDRL, white blood cell count, and protein
- Complete blood count (CBC) and differential and platelet count
- Long-bone X-rays
- Other tests as clinically indicated (e.g., chest X-ray, liver function tests, ophthalmologic exam)

Recommended Treatment:

- Aqueous crystalline penicillin G 100,000–150,000 units/kg body weight/day, administered as 50,000 units/kg body weight/dose by IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days

Scenario 2: Possible Congenital Syphilis

Infant with a normal physical exam **AND** an RPR titer ≤fourfold of the maternal titer at delivery **AND** one of the following:

- Inadequate or no maternal treatment or no documentation of treatment
- Maternal treatment with non-penicillin G regimen
- Maternal treatment was **initiated** <30 days before delivery

Recommended Evaluation:

- CSF analysis for VDRL, white blood cell count, and protein
- Complete blood count (CBC) and differential and platelet count
- Long-bone X-rays

Recommended Treatment:

- Aqueous crystalline penicillin G 100,000–150,000 units/kg body weight/day, administered as 50,000 units/kg body weight/dose by IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days *if any part of the evaluation is abnormal or not performed, the CSF is grossly contaminated, or follow-up as described in §4.2.3 is uncertain.*

OR

- Benzathine penicillin G 50,000 units/kg body weight/dose IM in a single dose *if all the recommended evaluation is performed, all results are available and normal, and follow-up as described in §4.2.3 is certain.*

Additional Considerations:

Infants born to birthing people with untreated early syphilis at the time of delivery may not have a reactive RPR and may have a normal clinical and laboratory evaluation. In this setting, the infant may have incubating or very early syphilis that is not yet clinically apparent. Therefore, even if follow-up as described in §4.3.2 is certain, infants should be treated with the 10-day regimen.

Scenario 3: Congenital Syphilis Less Likely

Infant with a normal physical exam **AND** an RPR titer ≤fourfold of the maternal titer at delivery **AND** both of the following are true:

- Birthing person was treated during pregnancy, treatment was appropriate for the syphilis stage, and the treatment regimen was initiated ≥30 days before delivery
- There is no evidence of maternal reinfection (i.e., no symptoms and titer has not increased fourfold or more)

Recommended Evaluation: None

Recommended Treatment:

- Benzathine penicillin G 50,000 units/kg body weight/dose IM in a single dose
- If follow-up is certain and maternal RPR titers decreased at least fourfold after therapy for early syphilis or remained stable for low-titer, latent syphilis (e.g., RPR<1:4), close RPR follow-up every 2-3 months for 6 months can be pursued instead of treatment.

Scenario 4: Congenital Syphilis Unlikely

Infant with a normal physical exam and an RPR titer ≤fourfold of the maternal titer at delivery **AND** both of the following are true:

- Maternal treatment was adequate before pregnancy
- Maternal RPR titers remained low and stable before and during pregnancy and at delivery

Recommended Evaluation: None

Recommended Treatment:

- No treatment required
- Benzathine penicillin G 50,000 units/kg body weight as a single IM injection should be considered if follow-up is uncertain and the infant has a reactive RPR

4.1.2 Infant Evaluation and Treatment: maternal reactive treponemal tests and a nonreactive RPR

1. **Reactive maternal treponemal tests with a nonreactive RPR during pregnancy:**
   - Congenital syphilis is highly unlikely for infants born to people with a nonreactive RPR after adequate treatment for syphilis during pregnancy or documentation of adequate treatment before pregnancy (with no evidence of reinfection)

- If the maternal RPR remains nonreactive at delivery and the infant has a normal physical examination and nonreactive RPR, manage like *Scenario 4: Congenital Syphilis Unlikely* scenario above. Benzathine penicillin G 50,000 units/kg body weight as a single IM injection might be considered if syphilis exposure is possible within 1 month before delivery and follow-up is uncertain.

2. **One reactive maternal treponemal test (e.g., EIA reactive, RPR nonreactive, TP-PA nonreactive) during pregnancy:**
   - Congenital syphilis is unlikely for infants born to people screened with the reverse sequence algorithm with an isolated reactive maternal treponemal test
   - If the infant has a normal physical examination and the risk for maternal syphilis is low, no evaluation and treatment are recommended for the infant
   - If maternal syphilis exposure is possible or unknown, repeat testing within 1 month is recommended to evaluate for early infection
3. **Reactive maternal treponemal test at delivery and no previous syphilis history or testing:**
   - Confirmatory testing is needed
   - If late or no prenatal care, the infant should be evaluated and treated with a 10-day course of penicillin as recommended in *Scenario 1: Confirmed Proven or Highly Likely Congenital Syphilis* above unless/until maternal syphilis is ruled out

4.1.3 Infant Follow-Up

- All infants with a reactive RPR at birth should receive thorough follow-up examinations and RPR testing every 2–3 months until the test becomes nonreactive*. Treponemal tests should not be used to evaluate infant infection status or treatment response*—these results are qualitative and passive transfer of maternal treponemal antibodies might persist for >15 months.
  - Treated infants who have persistent RPR titers by age 6–12 months should be reevaluated through CSF examination and managed in consultation with an expert. Retreatment with a 10-day course of a penicillin G regimen might be indicated.
  - For infants who were not treated because congenital syphilis was considered less likely or unlikely, RPR titers should decrease by age 3 months and be nonreactive by age 6 months, indicating that the reactive test result was caused by passive transfer of maternal antibodies
    - If the RPR is nonreactive at age 6 months, no further evaluation or treatment is needed
    - If the RPR is still reactive at age 6 months, the infant is likely infected and should be treated
- Infants with a negative RPR at birth born to people with a reactive RPR at delivery should be retested at age 3 months to rule out incubating congenital syphilis

- Infants whose initial CSF evaluations are abnormal do not need repeat lumbar puncture unless they exhibit persistent RPR titers at age 6–12 months. Persistent RPR titers and CSF abnormalities should be managed in consultation with an expert.

4.2 Management of Infants and Children Aged ≥1 Month

- Infants and children aged ≥1 month with reactive RPR and/or treponemal tests for syphilis should be examined thoroughly and have maternal serology and records reviewed to assess whether they have congenital or acquired syphilis
  - In the case of extremely early or incubating syphilis at the time of delivery, all maternal serologic tests might have been negative
  - Any infant or child at risk for congenital syphilis should receive a full evaluation and testing for HIV infection
- International adoptee, immigrant, or refugee children from countries where treponemal infections (e.g., yaws or pinta) are endemic might have reactive RPR and treponemal tests, which cannot distinguish between syphilis and other subspecies of *T. pallidum*. These children might also have syphilis and should be evaluated for congenital syphilis.

Recommended Evaluation:

- CSF analysis for VDRL, white blood cell count, and protein
- Complete blood count (CBC) and differential and platelet count
- Other tests as clinically indicated (e.g., chest X-ray, liver function tests, ophthalmologic exam)

Recommended Treatment:

- Aqueous crystalline penicillin G 200,000–300,000 units/kg body weight by IV, administered as 50,000 units/kg body weight every 4–6 hours for 10 days
- If there are no clinical manifestations of congenital syphilis and the evaluation is normal, treatment with up to 3 weekly doses of benzathine penicillin G 50,000 units/kg body weight IM can be considered
- These treatment regimens should also be adequate for children who might have other treponemal infections

Follow-up:

- Thorough follow-up examinations and RPR testing of infants/children treated for congenital syphilis after the first 30 days of life should be performed every 3 months until the test becomes nonreactive or the titer has decreased fourfold. *Treponemal tests should not be used to evaluate infant infection status or treatment response*—these results are qualitative and passive transfer of maternal treponemal antibodies might persist for >15 months.
- The titer response after therapy might be slower than for infants aged <1 month
- If titers increase at any point for >2 weeks or do not decrease fourfold after 12–18 months, the infant or child should be evaluated (e.g., CSF

examination), treated with a 10-day course of parenteral penicillin G, and managed in consultation with an expert.

- Infants/children whose initial CSF evaluations are abnormal do not need repeat lumbar puncture unless their RPR titers do not decrease fourfold after 12–18 months. After 18 months of follow-up, abnormal CSF results that persist and cannot be attributed to other ongoing illness indicate that retreatment is needed for possible neurosyphilis and should be managed in consultation with an expert.

5. MANAGING SPECIAL SITUATIONS

5.1 Infants Placed in Oregon Department of Human Services (DHS) Custody

When an infant is classified as a CS case and/or has a reactive RPR at birth, and is placed in ODHS custody:

- The county investigating the CS case should attempt to obtain information about where in Oregon the child will be residing and contact information for the child's pediatrician if known
- The county investigating the CS case should then notify the county where the child is residing so that the county of residence can monitor infants with a reactive RPR at birth for testing every 2–3 months until the RPR becomes nonreactive

GLOSSARY

CSF: Cerebrospinal fluid. CSF testing can indicate whether there is central nervous system involvement in a syphilis infection.

CBC: Complete Blood Count. A complete blood count is a set of tests that provide information about the cells in a person's blood. The CBC indicates the counts of white blood cells, red blood cells, and platelets, and the hemoglobin and hematocrit.

Early syphilis: Any of the stages that occur in the first 12 months of infection: primary, secondary, and early non-primary non-secondary syphilis.

IM: Intramuscular. An IM injection delivers medication, such as benzathine penicillin G for syphilis, into a muscle.

PCR: Polymerase chain reaction test is a laboratory technique for rapidly producing (amplifying) many copies of a specific segment of genetic material, e.g., *T. pallidum* DNA in syphilis.

RPR: Rapid plasma reagin test is a nontreponemal serologic (blood) test. Unlike treponemal tests, the RPR measures antibodies that are not specific for *T. pallidum* bacteria and may be reactive due to conditions other than syphilis, including pregnancy.

Treponemal test: Treponemal tests measure antibodies directed against T. pallidum bacteria. Treponemal serologic (blood) tests include enzyme immunoassays (EIAs) and chemiluminescence immunoassays (CIAs), T. pallidum particle agglutination (TP-PA),

fluorescent treponemal antibody absorption (FTA-ABS) tests, and point-of-care and self-test treponemal antibody tests. These qualitative tests usually remain reactive for life, regardless of treatment, following a syphilis infection.

VDRL: Venereal Disease Research Laboratory test is a nontreponemal test that can be done on blood and CSF. Mostly used in CSF testing in congenital syphilis and neurosyphilis evaluations. The RPR is the more common nontreponemal serologic (blood) test in Oregon.

REFERENCES

1. Oregon Administrative Rules. Oregon Health Authority Chapter 333 Public Health Division, Division 18 Disease Reporting. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=292908
2. Oregon Revised Statutes. Chapter 433 Disease and Condition Control. https://www.oregonlegislature.gov/bills_laws/ors/ors433.html
3. Oregon Administrative Rules. Oregon Health Authority Public Health Division Chapter 333 Division 19 Investigation and Control of Diseases: General Powers and Responsibilities. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=292879
4. Ingraham NR. The value of penicillin alone in the prevention and treatment of congenital syphilis. Acta Dermato Veneriologica. 1951;31:60–88.
5. CDC Syphilis (*Treponema pallidum*) 2026 Case Definition. https://ndc.services.cdc.gov/case-definitions/syphilis-treponema-pallidum-2/
6. CDC Sexually Transmitted Infections Treatment Guidelines, 2021. https://www.cdc.gov/std/treatment-guidelines/default.htm

UPDATE LOG

July 2023. First draft. (Jillian Garai, Yuritzy Gonzalez Pena, Timothy Menza)
July 2026. Surveillance case definition updated in accordance with 2025 CSTE syphilis position statement and 2026 CDC syphilis case definition. Other edits made throughout to align with current surveillance case definition. (Garai)

Appendix A

2026 Congenital Syphilis Surveillance Case Definition

The Centers for Disease Control (CDC), Division of STD Prevention (DSTDP), Surveillance and Data Science Branch developed this document as a technical resource for State, Tribal, Local, and Territorial (STLT) health departments that submit syphilis case data to CDC through National Notifiable Diseases Surveillance System for national surveillance. It is intended for recipients of PS19-1901 (Strengthening STD Prevention and Control for Health Departments) and PS23-2302 (Accelerating the Prevention and Control of HIV, Viral Hepatitis, STDs, and TB in the U.S.-Affiliated Pacific Islands). This document provides technical resources to support syphilis surveillance strategies described in those NOFOs. It does not introduce new NOFO requirements or represent official CDC recommendations. References to non-CDC websites do not constitute or imply endorsement.

DRAFT: 04.2026

Use this resource to assess whether a stillborn, infant, or child meets the Congenital Syphilis surveillance case definition and to classify a case as Probable or Confirmed.

This resource supports determination of

- Whether exposure to *Treponemal pallidum* (syphilis) occured during pregnancy or at delivery
- Whether Congenital syphilis was prevented by adequate treatment before delivery

Important information

- A stillborn, infant, or child can meet the surveillance case definition **even without signs or symptoms.**
- Surveillance and clinical case determination usually agree, but not always.
- The Congenital syphilis surveillance case definition is intentionally broad (sensitive).
- Most Congenital syphilis surveillance cases are **Probable**. **Confirmed** cases are uncommon.

Before you begin, gather available information, typically

- Maternal syphilis testing, diagnosis, and treatment history, and birth outcome
- Stillborn, infant, or child information: laboratory results, gestational age and/or weight, and clinical findings, if available

How to use this resource

STEP 1. Identify the proximate maternal infection

Identify the maternal infection closest in time (proximate) to the pregnancy or delivery using the Identifying the Proximate Maternal Infection flowchart.

Tip: Use the proximate maternal infection identified in STEP 1 to evaluate epidemiologic linkage in STEP 2.

STEP 2. Determine the case classification

Use the flowchart that matches the birth outcome **(stillborn** or **liveborn)** to determine whether the case meets the Congenital syphilis surveillance case definition and whether it is classified as a **Probable case**, **Confirmed case**, or **Not a case**:

- Flowchart: Case Classification for a **Stillborn**
- Flowchart: Case Classification for a **Liveborn** Infant or Child

NOTE: This document includes hyperlinks that connect within the document as well as links to external resources.
RESOURCES: 2026 Congenital syphilis surveillance case definition

Use this worksheet to record information as you work through the Congenital syphilis surveillance flowcharts.

Record IDs

Local use

STEP 1. Identify the proximate maternal infection

Proximate maternal infection

- ☐ **NO** surveillance evidence of a proximate maternal infection
- ☐ **YES,** proximate maternal infection identified

If yes, *record the promixmate maternal infection information from STEP 1 flowchart:*

Diagnosis[1] date: _____ Surveillance stage: _____

- ☐ Before this pregnancy
- ☐ During this pregnancy
- ☐ At delivery
- ☐ After delivery

STEP 2. Determine the case classification

Vital status

- ☐ Stillborn (fetal death)
- ☐ Liveborn - born alive, living
- ☐ Liveborn - born alive, then died

Case classification

- ☐ Confirmed case
- ☐ Probable case
- ☐ Not a case

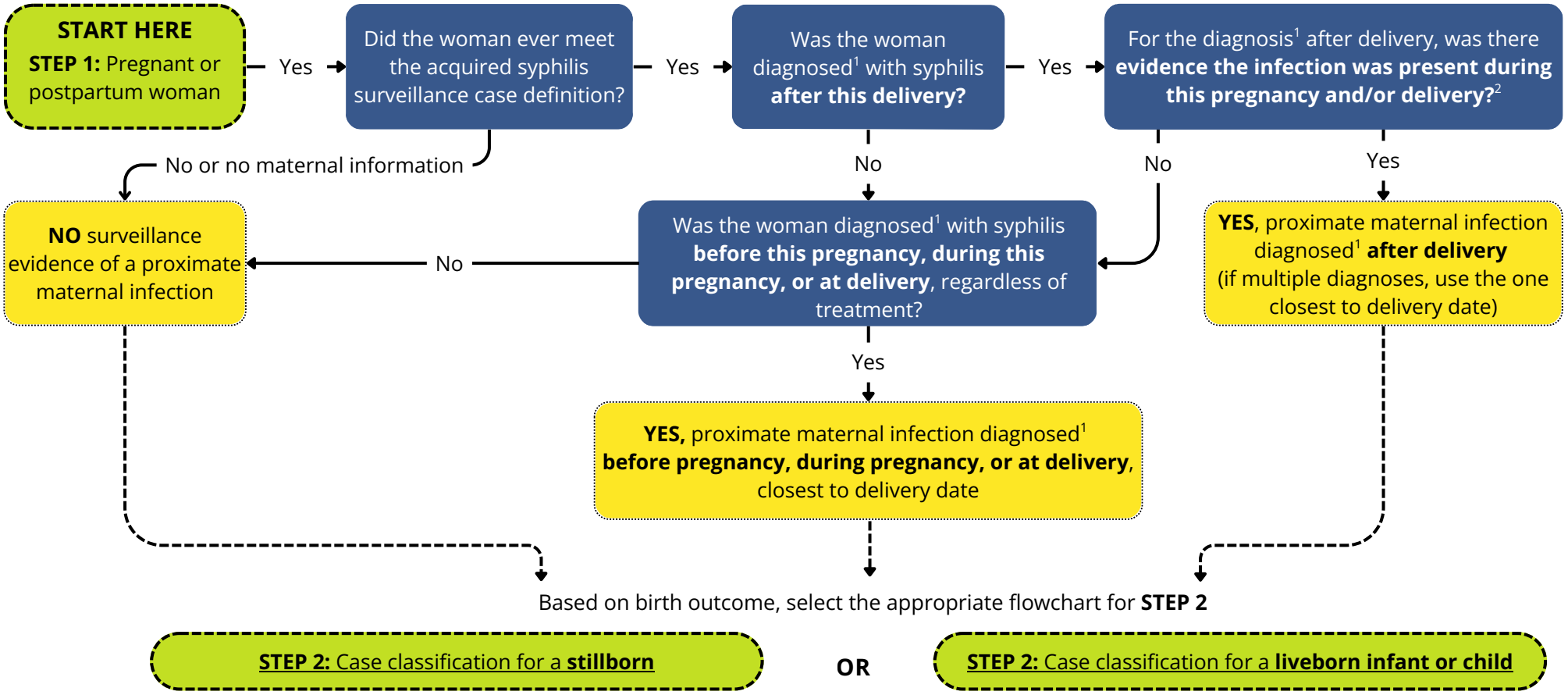
Notes

[1] Diagnosed means the woman met the surveillance case definition for acquired syphilis. The diagnosis date is usually based on the specimen collection date for the specimen(s) that led to case classification.
NOTE: This worksheet can be completed electronically as a fillable PDF; it may also be printed for handwritten use.

Use this flowchart to identify the maternal syphilitic infection that may have exposed the stillborn, infant, or child to *T. pallidum* (syphilis) in utero or at delivery. This step is required before using the case classification flowcharts.

Note: The proximate maternal infection may be diagnosed before pregnancy, during pregnancy, at delivery, or after delivery. It may be the first infection or a reinfection, and it may be any surveillance stage. Treatment does not determine which infection is proximate. An infection can be proximate whether it was untreated, adequately treated, or inadequately treated. Treatment status is assessed later when applying epidemiologic linkage criteria. Identifying the proximate maternal infection alone does not meet the epidemiologic linkage criteria.

Once the proximate maternal infection has been identified in STEP 1, use the STEP 2 Congenital syphilis flowcharts to determine whether the stillborn, infant, or child meets the surveillance case definition for Congenital syphilis.



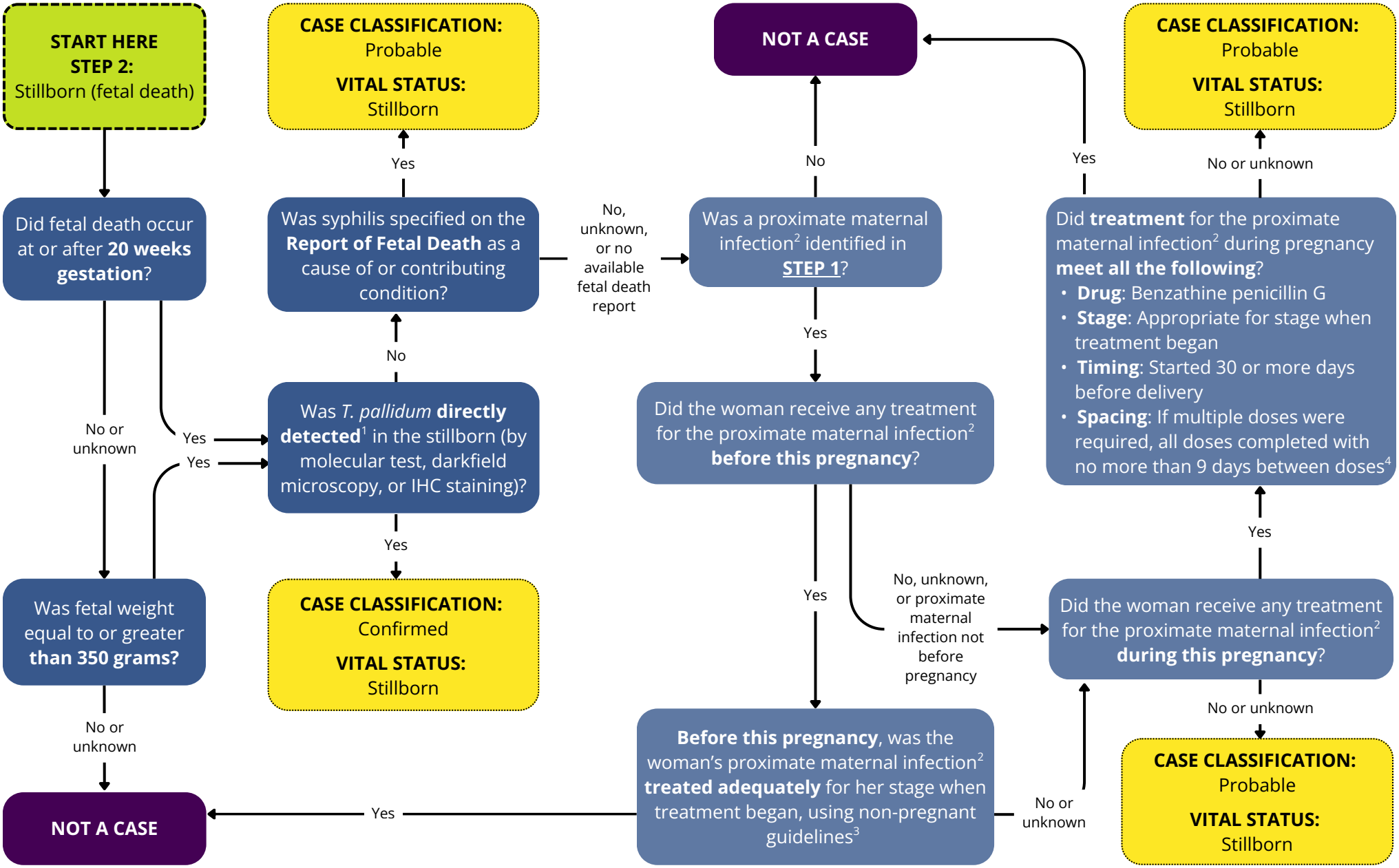
[1] Diagnosed means the woman met the surveillance case definition for acquired syphilis. The diagnosis date is usually based on the specimen collection date for the specimen(s) that led to case classification.
[2] Examples include, but are not limited to, the postpartum woman met the acquired syphilis surveillance case definition within 10 days of delivery (minimum incubation period) or had signs and/or symptoms of syphilis during pregnancy or at delivery. These examples do not cover every situation. Use all available information to decide whether she was infected before delivery, including possible exposure and other relevant clinical, laboratory, and epidemiologic information.

ACRONYMS: *T. pallidum* = *Treponema pallidum*
RESOURCES: 2026 Congenital syphilis surveillance case definition

STEP 2

Congenital Syphilis Surveillance Case Assessment Navigator (CS-SCAN): Case Classification for a **Stillborn**

This resource is based on the **2026** Congenital syphilis surveillance case definition and is not intended for clinical decision-making or to replace the syphilis surveillance case definition.



[1] Appropriate specimens are described in the CDC Laboratory Recommendations for Syphilis Testing. For example: molecular tests - lesion swabs, neonatal nasal discharge, neonatal blood or serum, autopsy material; darkfield - moist lesions, neonatal nasal discharge; IHC staining - brain, placenta, umbilical cord, lesion tissue. Specimens for darkfield and IHC staining cannot come from the oropharynx (mouth or throat) and cannot be potentially contaminated by stool (for example, specimen from the rectum or anus).

[2] A proximate maternal infection is the syphilitic infection closest to delivery that was present during this pregnancy or at delivery and could have exposed the stillborn to *T. pallidum* in utero or at delivery if not adequately treated before delivery. The proximate maternal infection may be identified before, at, or after this delivery. See STEP 1: Identifying the Proximate Maternal Infection flowchart.

[3] See CDC STI Treatment Guidelines for recommended treatment.

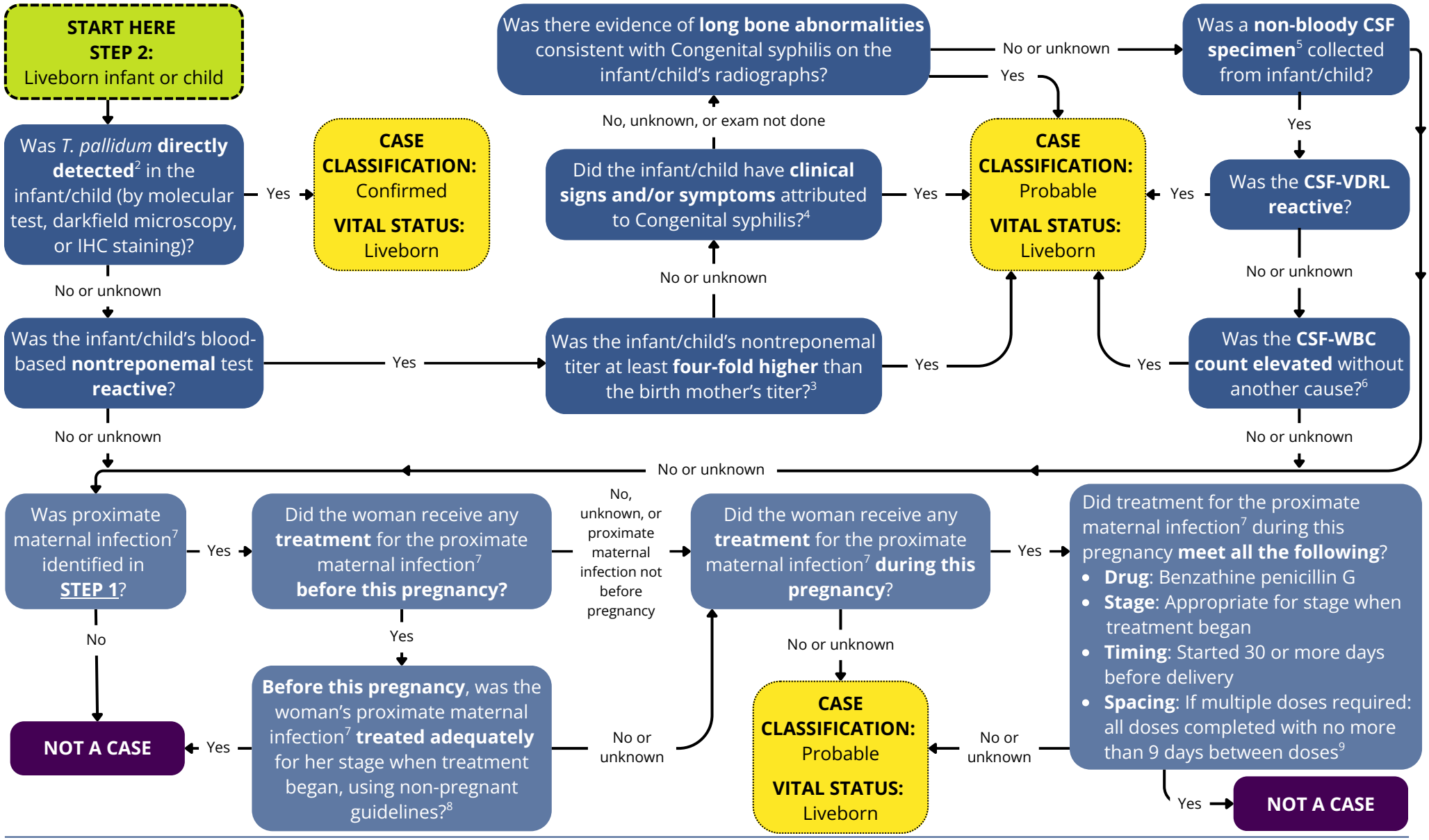
[4] CDC STI Treatment Guidelines do not define a minimum number of days between doses. Use local program guidance for the minimum interval.

ACRONYMS: IHC = Immunohistochemistry; *T. pallidum* = *Treponema pallidum*

RESOURCES: 2026 Congenital syphilis surveillance case definition

STEP 2 **Congenital Syphilis Surveillance Case Assessment Navigator (CS-SCAN)**: Case Classification for a **Liveborn** Infant or Child[1]

This resource is based on the **2026** Congenital syphilis surveillance case definition and is not intended for clinical decision-making or to replace the syphilis surveillance case definition.



[1] To classify as a Congenital syphilis surveillance case, the most likely source of syphilis exposure must be in utero or at delivery. If another source is more likely, use the acquired syphilis surveillance case definition.

[2] Appropriate specimens are described in the CDC Laboratory Recommendations for Syphilis Testing. For example: molecular tests - lesion swabs, neonatal nasal discharge, neonatal blood or serum, autopsy material; darkfield - moist lesions, neonatal nasal discharge; IHC staining - brain, placenta, umbilical cord, lesion tissue. Specimens for darkfield and IHC staining cannot come from the oropharynx (mouth or throat) and cannot be potentially contaminated by stool (for example, specimen from the rectum or anus).

[3] Compare maternal and infant blood-based titers from specimens collected within 7 days of birth and of each other.

[4] Signs and symptoms in infants or children are often non-specific and should be linked to congenital syphilis only if no more likely cause is present.

[5] CSF specimen must not be visibly bloody, defined as 500 or more RBCs per microliter. If RBCs are not available, the CSF should not be described as bloody in the medical record. If the CSF specimen is visibly contaminated, the result cannot be used for surveillance.

[6] Whenever possible, the treating clinician should interpret the results. For abnormal CSF WBC counts, refer to the latest CDC STI Treatment Guidelines.

[7] A proximate maternal infection is the syphilitic infection closest to delivery that was present during this pregnancy or at delivery and could have exposed the liveborn infant or child to *T. pallidum* in utero or at delivery if not adequately treated before delivery. The proximate maternal infection may be identified before, at, or after this delivery. See STEP 1: Identifying the Proximate Maternal Infection flowchart.

[8] See CDC STI Treatment Guidelines for recommended treatment.

[9] CDC STI Treatment Guidelines do not define a minimum number of days between doses. Use local program guidance for the minimum interval.

ACRONYMS: CSF = Cerebrospinal fluid; IHC = Immunohistochemistry; RBC = Red blood cell; *T. pallidum* = *Treponema pallidum*; WBC = White blood cell **RESOURCES**: 2026 Congenital syphilis surveillance case definition

Appendix B

CONGENITAL SYPHILIS (CS)

Evaluation and treatment of infants (<30 days old) exposed to syphilis in utero*

Start

INFANTS AND BIRTHING PARENT (e.g., mother) SHOULD HAVE SERUM RPR TITER DRAWN AT DELIVERY

Infant and Maternal Criteria

Infant Criteria:
- CS findings on physical exam
- Infant titer ≥fourfold higher than mother's titer
- + darkfield or PCR of placenta, cord, lesions, or body fluid
- + silver stain of placenta or cord

No to all

Maternal Criteria:
- Not treated
- Inadequately treated§
- Treatment undocumented
- Treated with a non-penicillin G regimen
- Initiated treatment <30 days before delivery

No to all

Additional Maternal Criteria:
- Adequately treated with penicillin G regimen appropriate for stage, initiated ≥30 days before delivery

AND

- No concern for reinfection or treatment failure

Yes to any

Scenario 1: Proven or Highly Probable CS

Yes to any

Scenario 2: Possible CS ||

Yes to both

Scenario 3: Less Likely CS

Infant Evaluation

- **CSF analysis†** VDRL, cell count, and protein
- **Complete blood count (CBC),** differential, and platelet count
- **Long-bone radiographs**
- **Tests as clinically indicated by signs on physical exam**

- **CSF analysis†** VDRL, cell count, and protein
- **CBC,** differential, and platelet count
- **Long-bone radiographs**

No additional infant evaluation

Review Maternal Titers & Stage:
- ≥4 fold decrease in titer after treatment for early syphilis

OR

- Stable titer for low-titer, latent syphilis (RPR < 1:4)

Any abnormalities, results not available, *OR* follow-up¶ uncertain

No abnormalities *AND* follow-up¶ certain

No to both *OR* follow-up¶ uncertain

Yes to either *AND* follow-up¶ certain

Infant Treatment

Aqueous crystalline penicillin G‡
100,000–150,000 units/kg/day, administered as 50,000 units/kg/dose IV every 12 hours during the first 7 days of life and every 8 hours thereafter for a total of 10 days

Benzathine penicillin G
50,000 units/kg/dose IM in a single dose

No treatment indicated
with close serologic follow-up of infant every 2-3 months for 6 months

* Scenario 4: CS Unlikely is not shown. This scenario covers infants with normal physical exam and RPR titer ≤fourfold of the maternal titer at delivery, and the mother was adequately treated prior to becoming pregnant and sustained RPR titers ≤1:4 throughout pregnancy.

† CSF test results obtained during the neonatal period can be difficult to interpret; normal values differ by gestational age.

‡ Alternative: Procaine penicillin G 50,000 units/kg/dose IM in a single daily dose for 10 days

§ Adequate treatment for syphilis in a pregnant person refers to the appropriate penicillin regimen recommended by the CDC initiated at least 30 days prior to delivery.

|| Evaluation is not necessary if a 10-day course of parenteral therapy is administered, although such evaluations might be useful. If the neonate's nontreponemal test is nonreactive and the mother's risk for untreated syphilis is low, a single IM dose of benzathine penicillin G (BPG) can be considered without evaluation.

¶ All neonates with reactive nontreponemal tests should receive careful follow-up examinations and serologic testing (i.e., a nontreponemal test) every 2–3 months until the test becomes nonreactive. Neonates with a negative nontreponemal test at birth whose mothers were seroreactive at delivery should be retested at 3 months to rule out serologically negative incubating congenital syphilis at the time of birth.

FOR MORE INFORMATION ABOUT SCENARIO 4 MANAGEMENT, TREATMENT OF SYPHILIS IN PREGNANCY, NEONATAL CSF INTERPRETATION, AND CS INFANT FOLLOW-UP, PLEASE REFER TO THE CDC 2021 STI TREATMENT GUIDELINES.

Oregon Health Authority

Last updated: 3/22/22

AETC AIDS Education & Training Center Oregon AETC

Adapted with permission from CDPH/CAPTC

END HIV