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

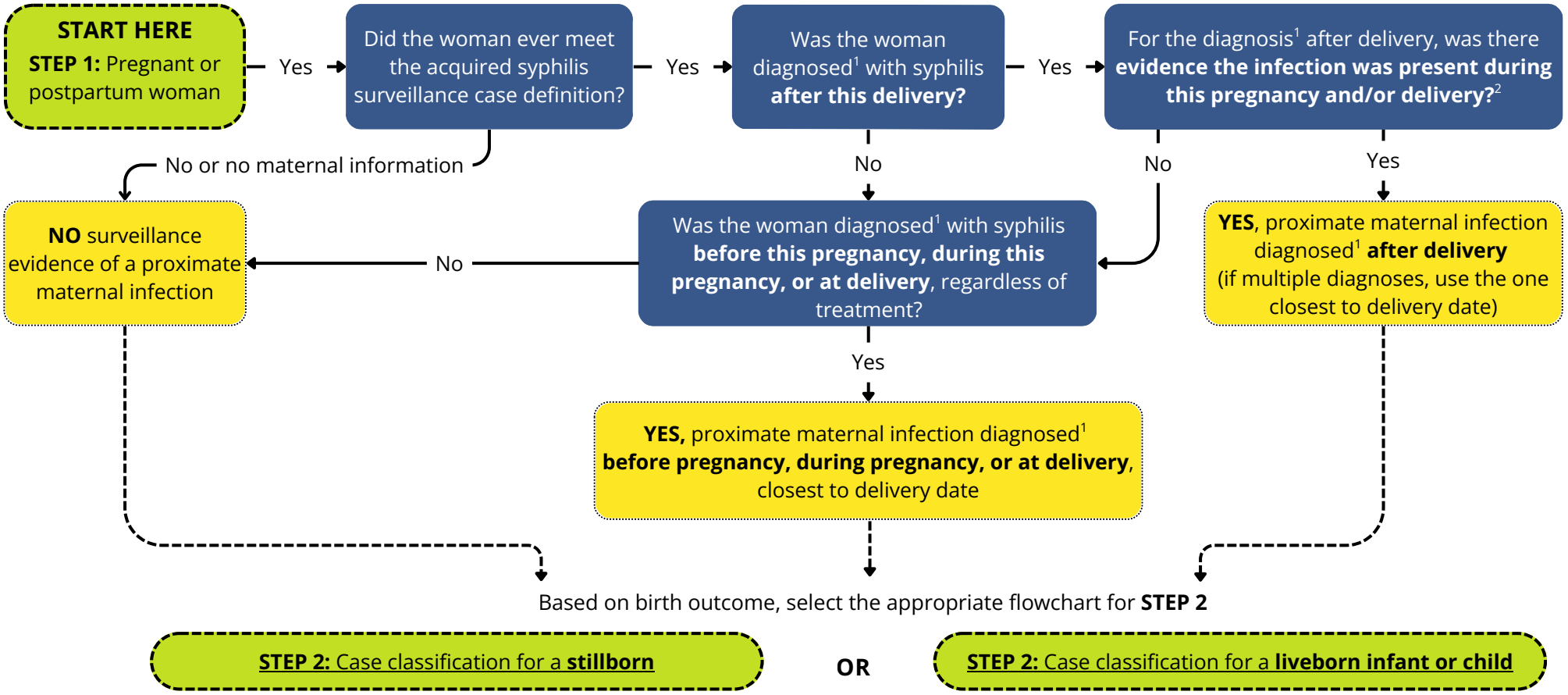
Notes

[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.



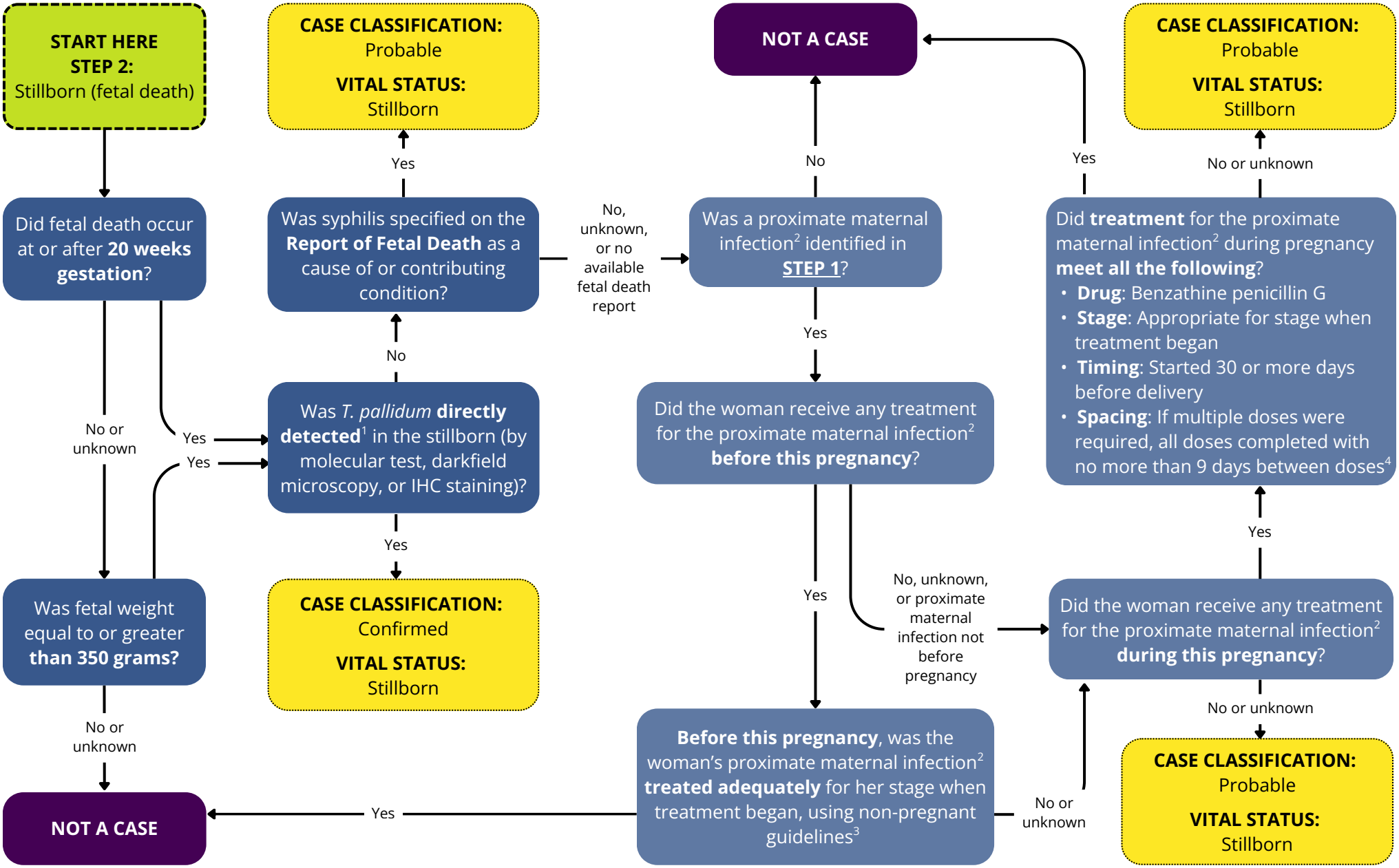
[1] Diagnosed means the woman met the surveillance case definition for acquired syphilis. The diagnosis date is usually based on the specimen collection date for the specimen(s) that led to case classification.
[2] Examples include, but are not limited to, the postpartum woman met the acquired syphilis 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]

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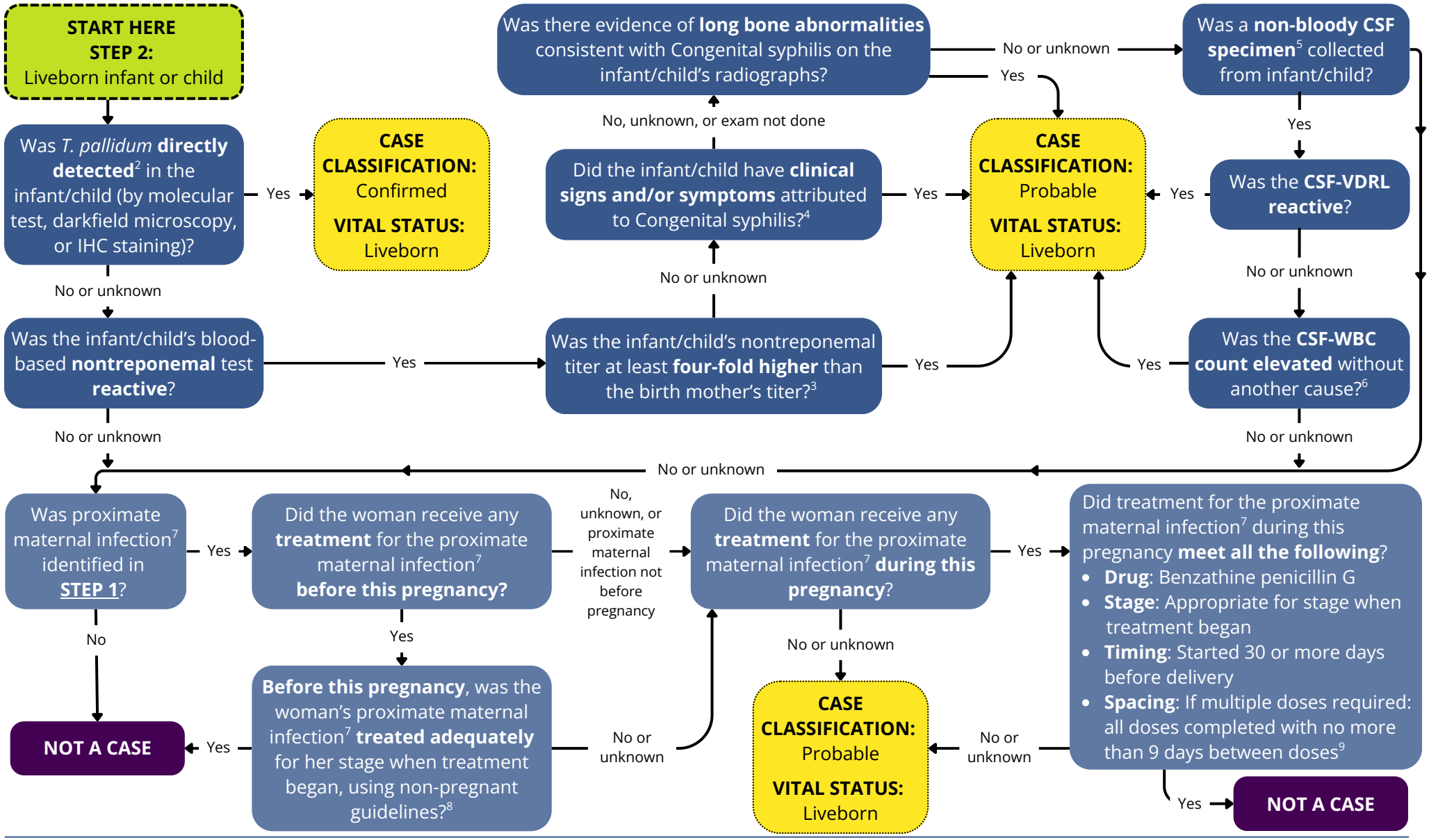

[1] To classify as a Congenital syphilis surveillance case, the most likely source of syphilis exposure must be in utero or at delivery. If another source is more likely, use the acquired syphilis surveillance case definition.

[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