Memorandum

To: Oregon Healthcare Providers

From: Pete Singson, MD

Date: February 25, 2025

Subject: Congenital Syphilis Crisis in Oregon

Dear Colleague,

The Oregon Health Authority (OHA) has reviewed preliminary 2024 data on sexually transmitted infections (STIs) in our state. While STI rates have stabilized in recent years, we are deeply concerned that congenital syphilis (CS) continues to rise at an alarming rate. In 2014, Oregon recorded two cases of CS. In 2024, that number surged to 45 — a staggering 2,150% increase. Although rates of syphilis infections in Oregon have decreased in alignment with national trends, syphilis diagnosed during pregnancy is increasing, resulting in more infants affected by this preventable disease.

While CS cases remain concentrated in urban areas, there is a growing number of syphilis cases during pregnancy in rural and frontier counties — CS cases were reported in 12 counties in 2024, and 22 CS cases were outside the Portland metro area. The burden of CS disproportionately affects pregnant people of color, those who experience housing instability, have criminal justice involvement, use drugs, and/or have a history of STIs. Black/African American, American Indian/Alaska Native, Native Hawaiian and Pacific Islander, and Hispanic/Latine pregnant people in Oregon are disproportionately represented in this epidemic. It is critical to understand that these disparities are not due to race or ethnicity, but rather by the compounded effects of systemic racism, poverty, houselessness, incarceration, substance use, and stigma.

The consequences of untreated syphilis during pregnancy include miscarriage, growth restriction, preterm birth and fetal demise. In the newborn, nearly every organ system can be affected, and severe cases can result in neonatal death. CS is entirely preventable with timely diagnosis and treatment, but many barriers exist. Minimal or no prenatal care was associated with 75% of CS cases resulting in missed opportunities. Generations of clinicians have had

limited experience diagnosing syphilis due to its historically low prevalence, and the disease's nonspecific presentation — earning it the moniker "the great imitator" — make the diagnosis even more challenging. Addressing this crisis requires not only a concerted effort to educate providers and communities, but also expanded screening, treatment, and access to care.

As a public health officer writing about syphilis during Black History Month, I would be remiss if I did not acknowledge the Tuskegee Syphilis Study, one of the most egregious violations of medical ethics in U.S. history. Black men with syphilis were deliberately left untreated over a 40-year period (1932–1972) — despite the availability of penicillin as a cure — so researchers could study the natural course of the disease. This unethical study reinforced deep-seated mistrust in the medical and scientific communities among Black Americans and other people of color. This distrust endures and continues to impact healthcare access and outcomes. We must work to rebuild trust by ensuring equitable, culturally responsive care that confronts the social conditions that drive the current CS crisis.

Strategies to Combat the Congenital Syphilis Epidemic in Oregon

1. **Universal Screening and Immediate Treatment for Syphilis in Pregnancy**: Follow the Centers for Disease Control and Prevention (CDC) and the American College of Obstetrics and Gynecology (ACOG) guidelines for syphilis screening at least three times during pregnancy — at first prenatal visit, 28 weeks/early third trimester, and at delivery. Screen all patients with no or limited prenatal care for syphilis at any opportunity. Begin treatment for syphilis diagnosed during pregnancy as soon as possible, ideally **30 days or more prior to delivery** to reduce the risk of CS.

2. **Expand Syphilis Screening**: Liberalize syphilis screening in emergency departments, urgent care centers, drug treatment facilities, and carceral care settings. Test for pregnancy in people seeking STI testing or care. Screen all pregnant patients for syphilis. Always default to ordering a syphilis screening cascade.

3. **Empiric Treatment Without Delay**: If a patient's history and clinical assessment are consistent with syphilis infection — and there are concerns about follow-up — test and begin empiric treatment immediately, even if test results have not yet resulted.

4. **Strengthen Partnerships with Local Public Health**: CS prevention is a public health priority. Local health departments follow up on all cases of syphilis, can provide past syphilis lab results and treatment information, and can assist with lab interpretation and treatment recommendations. **Work closely with your local health department** to ensure completion of syphilis treatment and facilitate sexual contact testing and treatment.

5. **Reinforce Syphilis Prevention Strategies**: Encourage consistent **condom use** and educate at-risk populations about doxycycline post-exposure prophylaxis (doxyPEP). DoxyPEP has been shown to reduce risk of syphilis and chlamydia by more than 70% and gonorrhea by more than 50% in men with male sexual contact and transgender women who have sex with men. Use a shared decision-making process when offering doxyPEP to other populations.

The CS epidemic in Oregon is a crisis, but it is controllable. With coordinated action, increased awareness, and commitment to equitable care, we can end this devastating disease and protect future generations of Oregonians.

Thank you for your dedication to the health of our communities.

Sincerely,

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Additional Resources

Syphilis and other STI treatment guidelines can be found in the CDC 2021 STI Treatment Guidelines.

Learn more about syphilis and earn CME at the National STD Curriculum.

OHA STI Syphilis and Congenital Syphilis dashboards offer additional data reports on county level case numbers, incidence rates, and demographics.

In June 2024, CDC released Clinical Guidelines on the Use of Doxycycline Postexposure Prophylaxis for Bacterial Sexually Transmitted Infection Prevention.

In addition, providers can consult the National STD Clinical Consultation Network.