Questions and Answers from Webinar #1

Questions about the case scenarios:

1. **Answers to the case scenarios**
   a. Case #1: Secondary Syphilis
   b. Case #2: Early Non-Primary Non-Secondary Syphilis
   c. Case #3: Unknown Duration or Late Syphilis
   d. Case #4: Unknown Duration or Late Syphilis (with Ocular Manifestations)
   e. Case #5: Early Non-Primary Non-Secondary Syphilis (see comments below)
   f. Case #6: Not a case (see comments below)

2. **What was the final answer to #5?** Early Non-Primary Non-Secondary

3. **When was case #5 treated?**
   You’re right - we should have been more clear about this patient’s treatment history. For this case, the intention was to present a case that was previously treated, had adequate response to treatment, but had a persistent positive titer at 1:2 after treatment. So the 1:2 six months ago was his baseline, and now he has a titer of 1:32 but no symptoms.

4. **For case #5, are we assuming the patient was treated when the physician diagnosed? Does that affect staging?** For this case, our intent was to illustrate a scenario where the clinician didn’t observe symptoms but the DIS did. We were assuming that the patient had NOT been treated between the clinician visit and the DIS interview. Because the surveillance stage should be based on the clinician exam/visit where the syphilis tests were done, this patient should be assigned a surveillance stage of Early Non-Primary Non-Secondary Syphilis. (If the patient had been treated before the DIS interview, and now the DIS was seeing signs/symptoms of secondary syphilis, that raises the question of whether the patient has been re-infected.)

5. **For case #5 if the provider had not re tested and they often don’t would you agree this would be early latent?** Case #5 had a titer increase from 1:2 to 1:32 (and we didn’t present info on whether or not he was re-tested). He should be assigned a surveillance stage of Early Non-Primary Non-Secondary Syphilis. Case #6 is the case that went from 1:8 → 1:64 → 1:16. If Case #6 had not been re-tested after the 1:64 titer (e.g., if the clinician treated immediately based on the titer increase to 1:64 and there was no follow-up titer to show that his increased titer was not sustained), then agreed this case would meet the case definition for Early Non-Primary Non-Secondary Syphilis.

6. **Case #5. What if the exam took place after initial testing (outreach event, lab only) when the Pt has come back for treatment? Would that exam count?** If the patient was tested at an outreach event (without exam), then saw a clinician who observed no signs/symptoms, then was interviewed by DIS who observed signs/symptoms of secondary syphilis (and assuming all these took place before treatment), then the surveillance stage would be based on patient’s stage at the time the syphilis testing was done (i.e., at the outreach event).

7. **Case #6: WHEN is he called back?** We were intending to illustrate a case that had a >4x increase in titer, was retested a couple of weeks later to follow-up that result, and the follow-up titer showed that the increase was not sustained.

8. **Case#6- was patient tested by same lab?** For the purposes of this case, yes, we were assuming all these titers were tested by the same lab.

9. **Would any of these been different if the collecting entity was a blood product facility and perhaps there was no 'true examination' performed?** It is not possible to accurately stage a
patient based on laboratory results only (accurate staging requires knowledge of the patient’s signs/symptoms). If a patient is tested as part of an outreach screening program before any exam, surveillance stage should be assigned based on the stage of the patient at the time the syphilis testing was done.

Other Questions:

10. **What if a follow-up test was not performed after a >4-fold increase of nontreponemal titer? (Early non-primary non-secondary)** If no follow-up test is done, then the staging would be based on the >4-fold titer increase and the patient would be staged as Early Non-Primary Non-Secondary. A follow-up test is not required. However, IF a patient DOES have a follow-up test, and this test shows the increase was not sustained, then the patient wouldn’t be a case (unless he/she met other criteria).

11. **Does a > 4 fold titer drop after treatment also hint at early syph?** No, titer response to treatment shouldn’t be used to stage a patient.

12. **Are DIS still trained to stage based on symptoms at time of treatment or are they now being trained to stage at time of specimen collection?** I can’t speak to how DIS are trained, but the guidance since 2003 (from CDC’s 2003 Recommendations on Public Health Surveillance of Syphilis in the U.S.) has been the following: “Syphilis cases should be categorized and reported by stage at the time of initial examination (which is often the time of initial specimen collection), not at the time of treatment or interview.”

13. **What would the staging be if a patient was initially staged as secondary but then had a new exposure to a primary case?** It depends on timing of treatment and exposure. If Patient A had secondary syphilis, was treated, and then re-exposed to a primary case (Patient B), then Patient A needs to be re-treated as a contact. Patient A had already been reported as a Secondary case. If he met one of the case definitions again (i.e., had evidence of re-infection after the original treatment and re-exposure to Patient B), he should be reported as a new case according to the stage at the time of the exam/testing that provided evidence that he was re-infected and was a new case. On the other hand, if Patient A was staged as secondary and then exposed to Patient B with primary syphilis BEFORE Patient A was treated, then this would not change how Patient A was staged.

14. **What if the last non-treponemal titer was non-reactive then a subsequent titer was reactive? Is that considered a second infection? Is there a timeframe/time limit for comparison of titers?** For persons with a previous history of syphilis treatment, it is not uncommon to go back and forth between having a non-reactive titer and having a low-level reactive titer (e.g., 1:1 or 1:2). In these patients, I would not consider these fluctuations to be evidence of re-infection. It can be challenging to determine what the “true” baseline titer is for these patients, and this requires clinical judgment. With regards to a timeframe for evaluating an increase, the CDC treatment guidelines refer to “a fourfold increase in nontreponemal test titer persisting for >2 weeks” as evidence of treatment failure or reinfection.

15. **Will the CSTE be releasing a simplified staging algorithm for primary care and prenatal physicians?** CDC has a new provider syphilis pocket guide which includes information on staging. CSTE and CDC will also be revising a staging algorithm tool for DIS.
16. **Will the disease/diagnosis codes be changing?** The codes for Primary, Secondary, and Early Non-Primary Non-Secondary will be staying the same (i.e., 710, 720, 730, respectively), but there will be a new code for Unknown Duration or Late Syphilis.

17. **Why do titers rise if pt's aren't infected?** There are many factors other than syphilitic infection that can potential affect RPR titers. Remember that other infections, autoimmune disease, older age, pregnancy, and drug use can all cause false positive RPRs. These factors could also affect titers in persons with a previous history of syphilis. In addition, there may be some variation between laboratories or between laboratory personnel in terms of how they perform the dilutions or report the titers.

18. **Could you go over the two fold increase compared to the four fold increase?** A fourfold increase in titer is equivalent to a change of 2 dilutions. An increase from 1:8 to 1:32 is a fourfold increase. A twofold increase would be a change from 1:8 to 1:16.

19. **If you have a negative non-treponemal test with a reactive treponemal antibody test, would this be considered a case?** For surveillance purposes, all surveillance stages other than primary syphilis require BOTH a reactive nontreponemal test AND a reactive treponemal test. If the person had a chancre consistent with primary syphilis and a reactive treponemal test, this person could be reported as a primary syphilis case.

20. **So can someone who has a palmar plantar rash, NR RPR, +TPPA be classified as secondary?** If so, aren't you worried about prozone reaction and possibly counting double morbidity on someone (if they have follow-up labs drawn)? The surveillance case definition for secondary syphilis requires symptoms AND a reactive nontreponemal test AND a reactive treponemal test, so this person would should not be reported as a secondary syphilis (unless repeat RPRs were positive). However, clinical management and programmatic management (e.g., partner services) might manage this as a secondary syphilis case.

21. **To be answered in the follow-up document... how will clinical manifestations be captured through data (i.e. will we create a new variable for ocular syphilis which mirrors what's currently done for neurologic involvement)?** There will be new variables added for ocular manifestations, otic manifestations, and late clinical manifestations. These will be discussed on the 2nd webinar on November 7th.

22. **When does this go into effect and will there be a grace period for us to work with our databases.** These changes go into effect on January 1, 2018. There will be a grace period. CDC will still accept cases reported with the old event codes. The event code for Early Non-Primary Non-Secondary Syphilis (what was previously called Early Latent Syphilis) will not change; only the name of this stage will change. There will be a new event code for Unknown Duration or Late Syphilis. Until jurisdictions complete the transition to reporting this new event code, CDC will re-classify cases reported with the old event codes for “Late Latent Syphilis” and “Late Syphilis with Clinical Manifestations” as the new category “Unknown Duration or Late Syphilis.” The logistics of data transmission and the transition will be discussed on future CSTE STD Surveillance Coordinators calls.

23. **Will the NETSS file be revised to include the changes? If so, when?** The NETSS file will be revised. The logistics of data transmission and the transition will be discussed on future CSTE STD Surveillance Coordinators calls.