SIFILIDE

Michele Trotta

Centro di Riferimento Regionale Toscano per le Malattie Infettive in Gravidanza

AOU Careggi

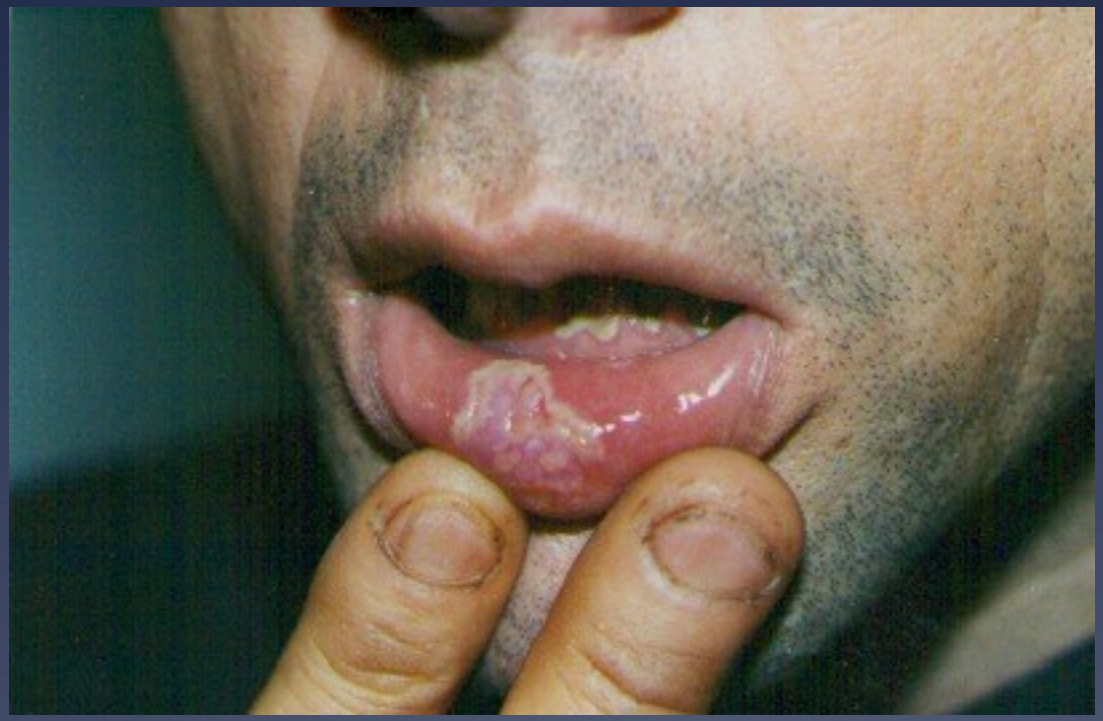
Modalità di trasmissione

* MTS
* Trasfusioni (non più)
* Trasmissione verticale
* Professionale (non più)

Classificazione

- Primaria compare dopo 2, 3 settimane (10 -90 giorni) dal contagio
- Secondaria compare dopo 2, 3 mesi dal contagio in 1/3 dei casi
- Latente precoce fino ad 1 anno dal contagio
- Latente tardiva dopo 1 anno dal contagio
- Sifilide tardiva 1/10 dei casi

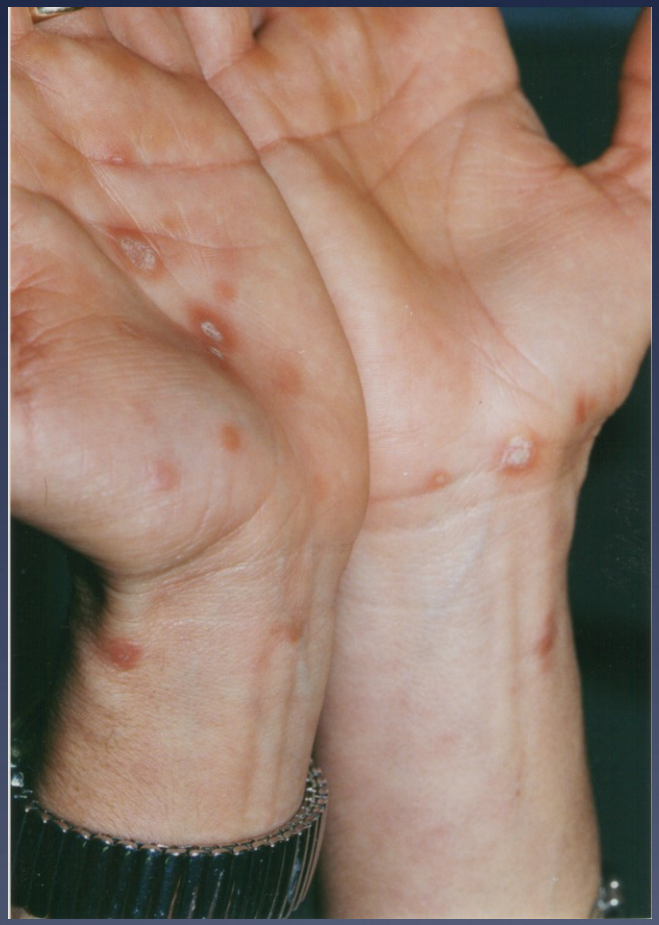
Sifiloderma secondario



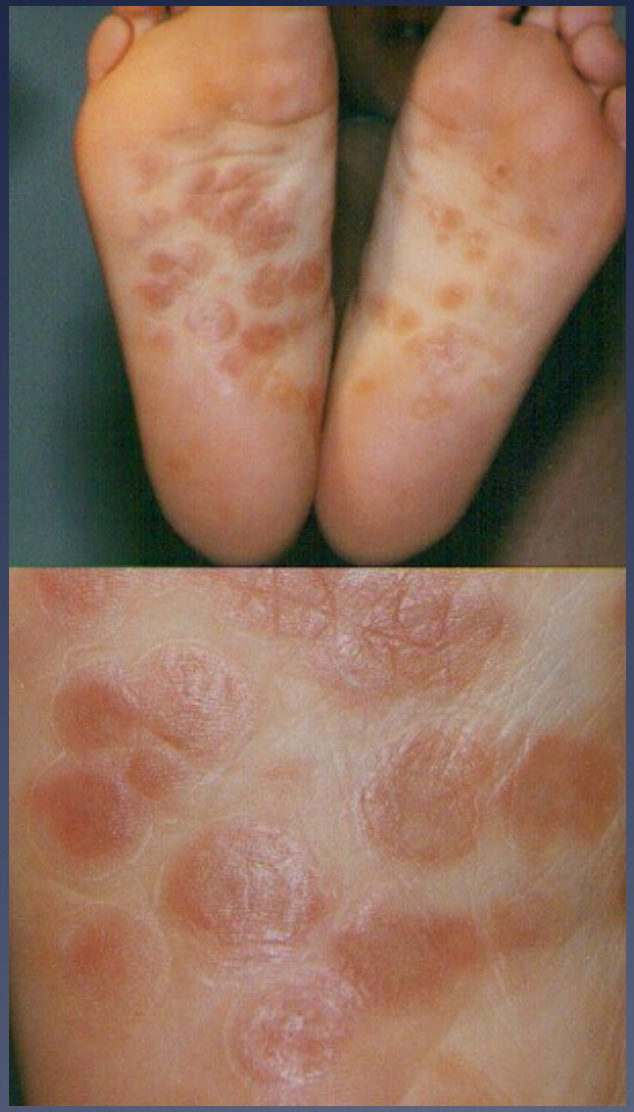
Secondaria

* Sifiloderma secondario
* Epatite
* Periostite
* Linfoadenite sistemica
* Sindrome nefrosica (rara)
* Uveite
* Meningite (quasi sempre asintomatica)

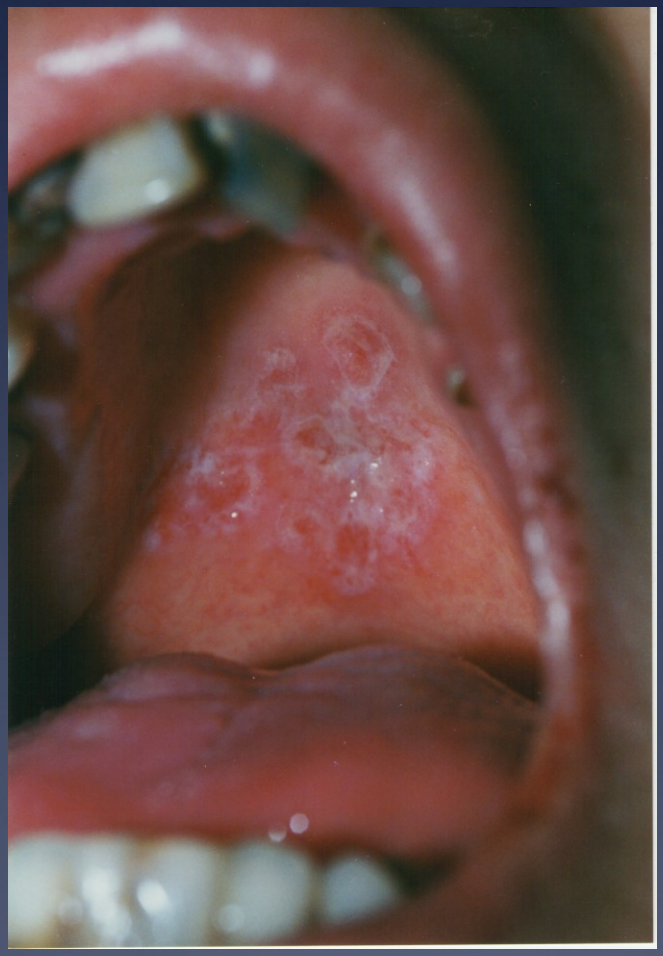
Sifiloderma secondario



Sifiloderma secondario



Sifiloderma secondario



Lue terziaria (tardiva)

* Neurosifilide asintomatica	early/late
* Meningovascolare	2 – 7 anni
* Paralisi Progressiva	10 – 20 anni
* Tabe dorsale	15 – 25 anni
* Cardiovascolare	10 – 30 anni
* Gomme	1 – 46 anni (media 15)

UK National Guidelines on the management of syphilis 2008

CLASSIFICATION

Syphilis is classified as acquired or congenital. Acquired syphilis is divided into early (primary, secondary and early latent <2 years of infection) and [redacted] tertiary including gummatous, cardiovascular and neurological) syphilis. Congenital syphilis is divided into early (diagnosed in the first two years of life) and late (presenting after two years).

IUSTI

International Union Against Sexually Transmitted Infections

Latent syphilis, early and late: positive serological tests for syphilis with no clinical evidence of treponemal infection. This is classified (ECDC definition) as early latent if the infection was acquired <1 year previously and as [redacted] Amplified definition of early latent syphilis: individuals who have had negative syphilis serology within one year of a syphilis diagnosis and who have no symptoms or signs of HIV disease, or individuals with positive syphilis serology who have unequivocal evidence that they have acquired syphilis in the previous twelve months.

Tests

* Esame diretto in campo oscuro: desueto
* Biopsia:solo raramente
* PCR: specifico ma non distingue i treponemi vivi da quelli morti. Delicato.
* RIT
* Tests sierologici: Treponemici e non treponemici

PCR

* Among primary syphilis, real-time PCR positivity was 80% in lesion swabs and 55% in serum, while among secondary syphilis it was 100% in plasma samples (Gayet-Ageron et al., 2009).

NTT

- The mean sensitivities of the VDRL during primary syphilis, secondary, latent and late latent are 78%, 100%, 95% and 71%, respectively;
- sensitivities of RPR are 86%, 100%, 98% and 73%. The mean specificities of both tests are 98% (Larsen et al., 1995).

TPHA

- The mean sensitivities of the TPHA during primary syphilis, secondary and latent syphilis are 88%, 100% and 98%, respectively, while the mean specificities are 95% (Pope et al., 2000).

FTA abs

- The mean sensitivities of the FTA-ABS during primary syphilis and late latent are 84% and 96%, respectively; while the sensitivities during secondary and recent latent syphilis are 100%. The mean specificities are 97%(Larsen et al., 1995). Until recently, FTA-ABS was considered the "gold standard" serological test for laboratorial diagnosis of syphilis.

WB

- The sensitivity were 92.3%, 100%, 94.4% and 94.1%, respectively for primary, secondary, early latent and latent of unknown duration clinical stages of syphilis (Lam et al., 2010).

RPR/VDRL

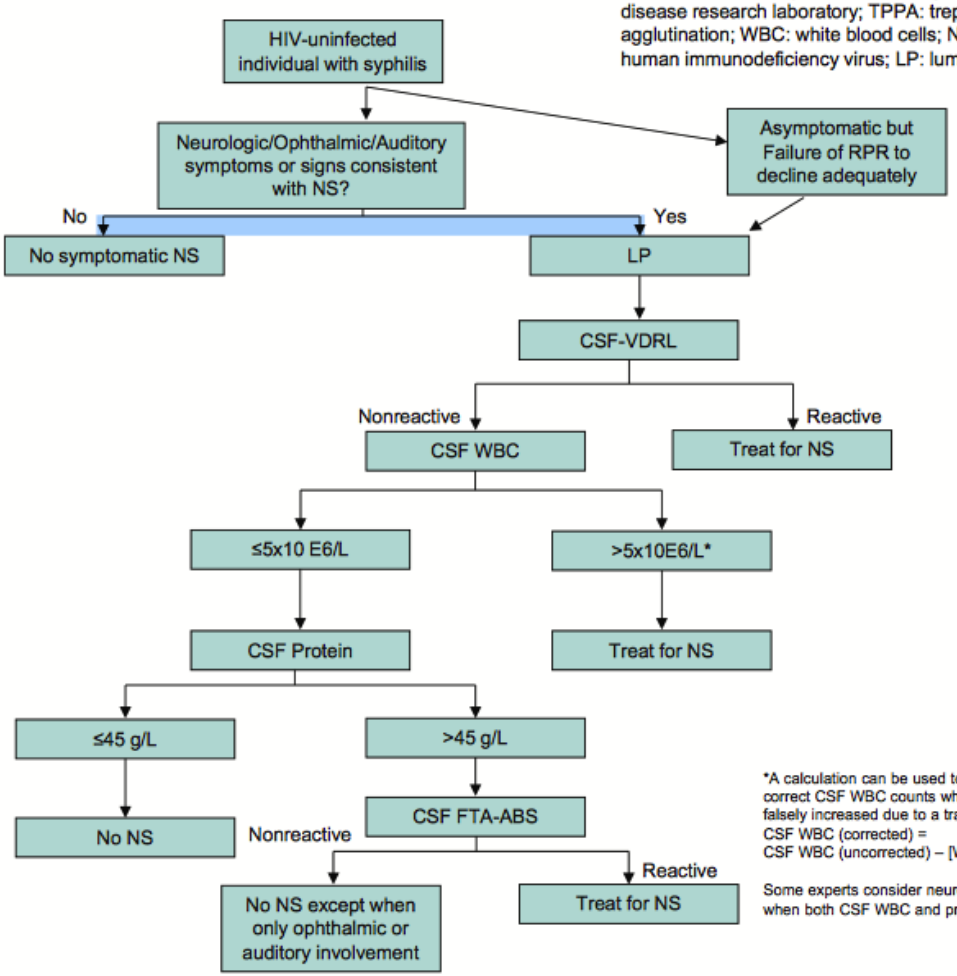
- Test fondamentali per la prognosi e la terapia
- Importanza del titolo e non dei +++
- Compare generalmente 6 settimane dall'infezione e 10 -15 giorni dopo il sifiloma, raggiungendo il picco a 1-2 anni per poi ridursi lentamente
- Negativizzazione nel 50% entro 12 mesi nella primaria
- Nelle forme recenti riduzione del titolo di 4 volte a 6 mesi, 8 volte a 12 mesi e12 volte a 24 mesi
- Se non si riduce il titolo entro 6 – 12 mesi: CSF ed eventuale ritrattamento (standard)

RPR/VDRL

- Negativizzazione entro 5 anni nella latente tardiva
- Il follow up va datto fino a negativizzazione/basso valore sostenuto
- In qualche caso non si negativizza mai (serofast reactor)
- In qualche caso negativizzazione spontanea

Neurosyphilis diagnosis

CSF: cerebrospinal fluid; EIA: syphilis enzyme immunoassay; FTA-ABS: fluorescent treponemal antibody absorption; VDRL: venereal disease research laboratory; TPPA: treponemal pallidum particle agglutination; WBC: white blood cells; NS: neurosyphilis ; HIV: human immunodeficiency virus; LP: lumbar puncture



*A calculation can be used to correct CSF WBC counts which are falsely increased due to a traumatic tap:
CSF WBC (corrected) =
CSF WBC (uncorrected) – [WBC(blood) x RBC(CSF) / RBC(blood)]

Some experts consider neurosyphilis as a diagnosis when both CSF WBC and protein are elevated

Adapted from Marra C.M.: *Neurosyphilis*: Uptodate on line, version 19.06.2013.

Lue in gravidanza

Diagnosi Materna

Passaggio transplacentare

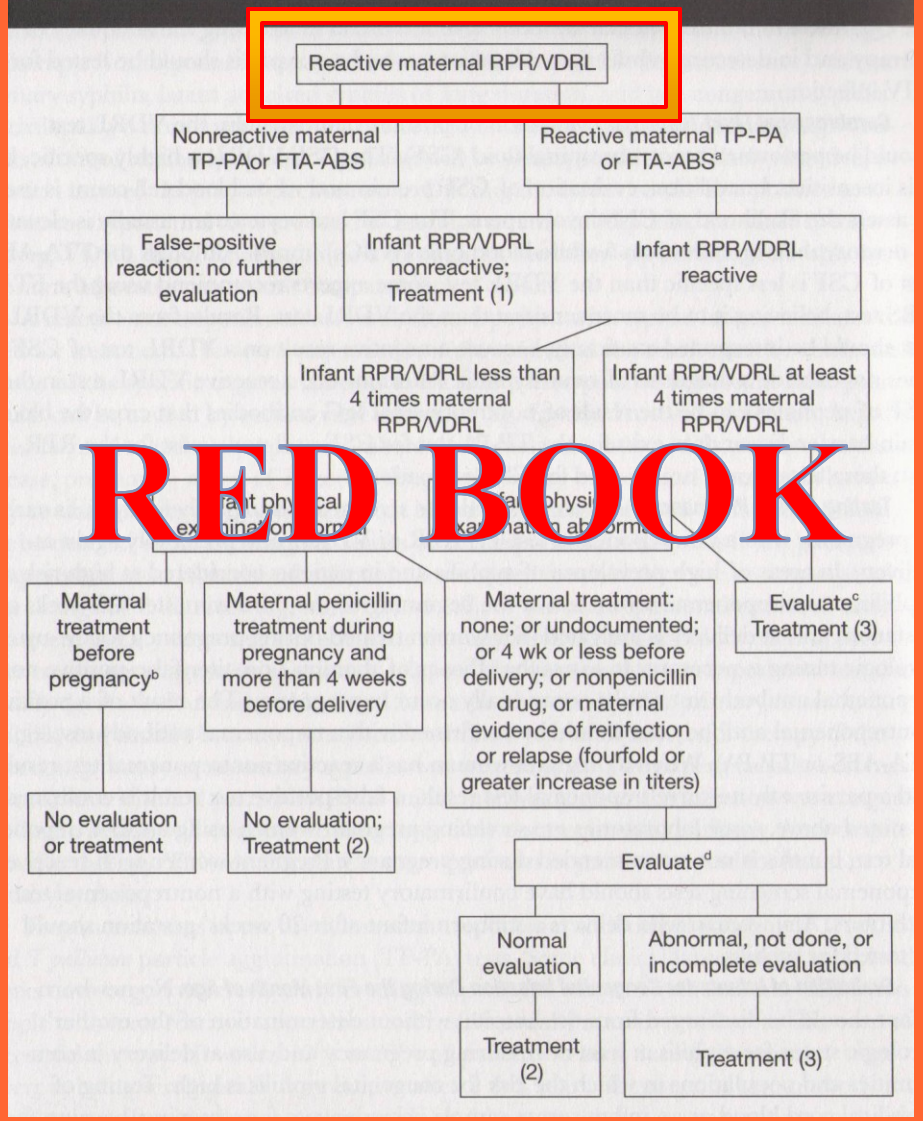
Diagnosi Fetale

Terapia

Outcome neonatale

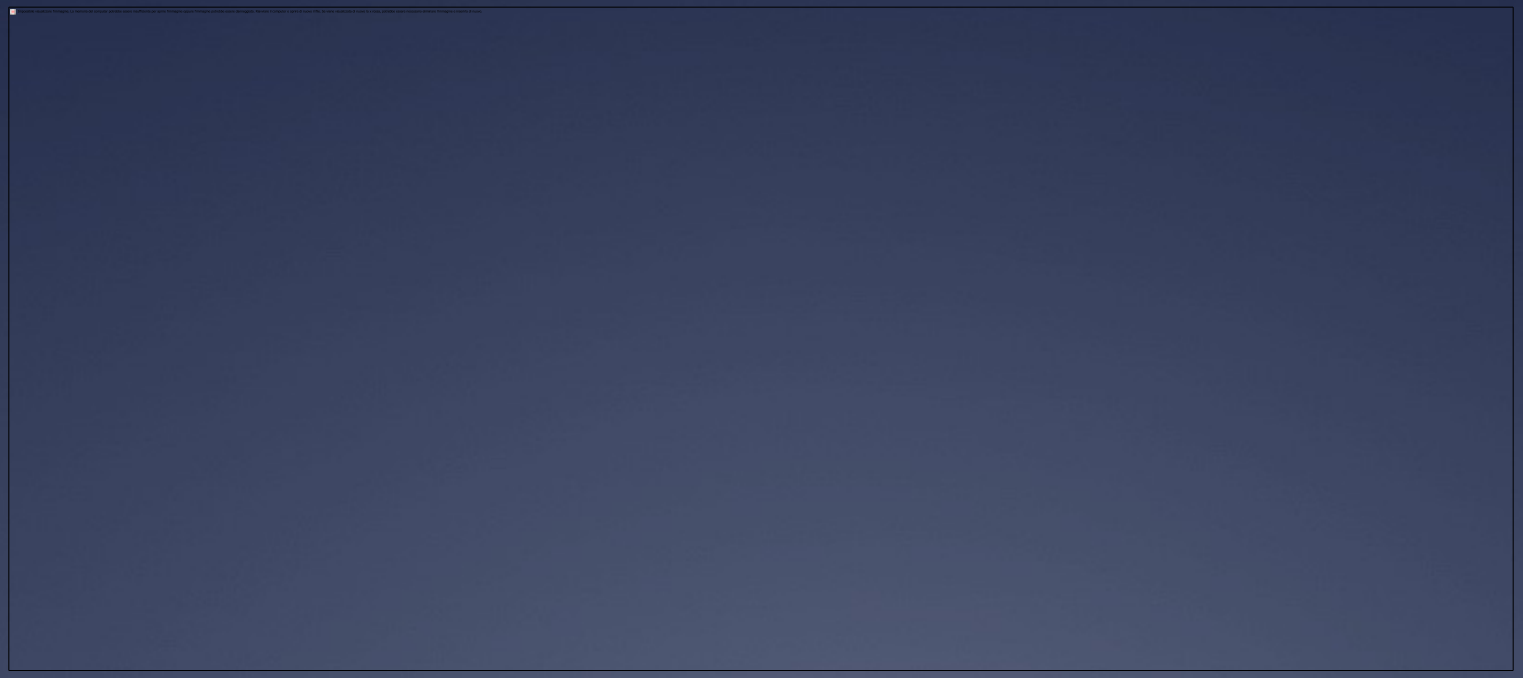
Diagnosi materna

FIG 3.6. ALGORITHM FOR EVALUATION AND TREATMENT OF INFANTS BORN TO MOTHERS WITH REACTIVE SEROLOGIC TESTS FOR SYPHILIS.



RED BOOK

Remington e Klein (Infectious Diseases of the Fetus and Newborn Infant)



The VDRL/RPR and EIA-IgM[27] are often negative in late syphilis but this does not exclude the need for treatment.

27 Michelow IC, Wendel GD, Norgard MV, *et al.* Central nervous system infection in congenital syphilis. *New Engl J Med* 2002;**346**:1792–8

In europa

- Primary screening test
  Option 1: a TT (TPHA, MHA-TP, TPPA or EIA/CIA)
- Option 2: a NTT (ideally quantitative) (RPR or VDRL)
- Option 3: both a TT and a NTT
- Option 1: another TT of a different type AND a quantitative NTT if second TT is positive
- Option 2: a TT
- Option 3: NTT must be performed quantitatively