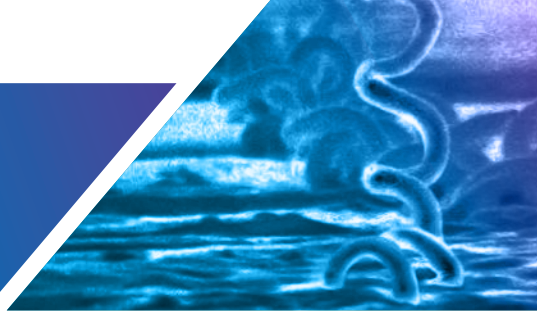
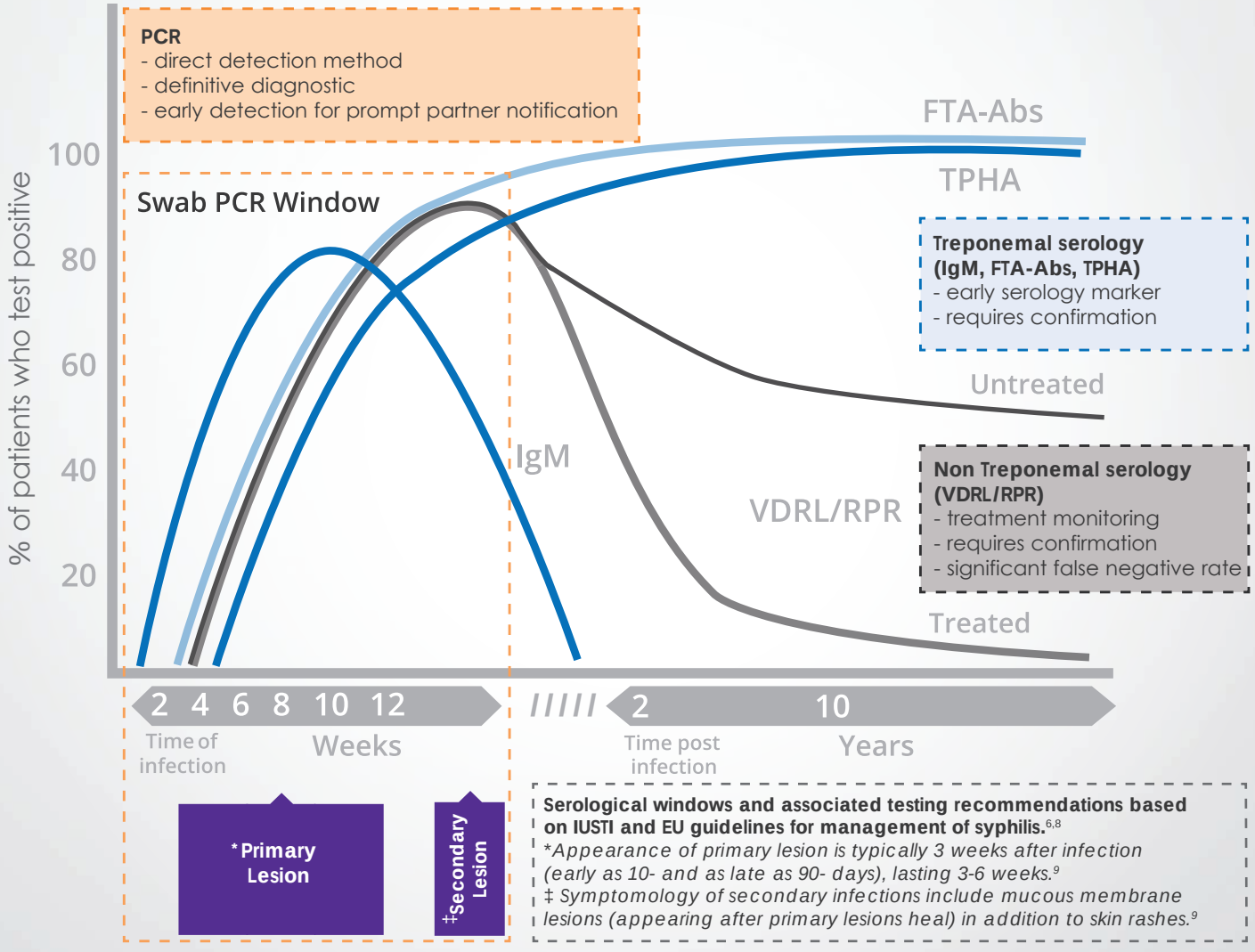
Syphilis on the rise



- Infection with the bacterium *Treponema pallidum* (TP), which causes syphilis, is now the second most likely cause of genital ulceration.[1]
- This past decade has seen a major increase in syphilis infection rates, reaching levels not seen since the 1940's.[2-4]
- Syphilis lesions can present atypically, be painful, and appear indistinguishable from herpes.[5-7]
- Dark-field microscopy is not suitable for oral or anal lesions, and is a skilled technique requiring experienced operators.[6,8]

Serology is not a definitive diagnostic tool



Serological windows and associated testing recommendations based on IUSTI and EU guidelines for management of syphilis.[6,8]

**Appearance of primary lesion is typically 3 weeks after infection (early as 10- and as late as 90- days), lasting 3-6 weeks.*[9]

‡ Symptomology of secondary infections include mucous membrane lesions (appearing after primary lesions heal) in addition to skin rashes.[9]

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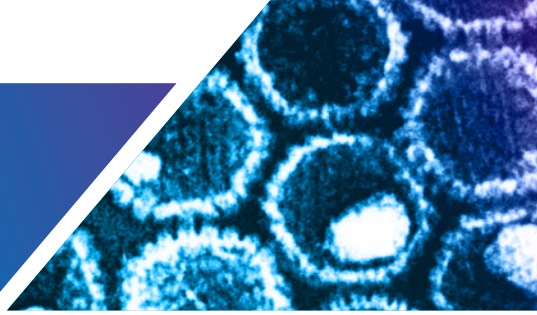
Genital/Oral Lesions
Diagnostic challenges



- Ulcerations or lesions in the ano-genital and oral regions can be caused by a variety of bacterial and viral infectious agents.[1,10]
- Symptomatic diagnosis of genital ulcers is often unreliable, with accuracy ranging from 33 to 80%.[11-13]
- Herpes simplex viruses (HSV-1 & HSV-2) are the most prevalent causative agents, however reported syphilis cases are increasing, particularly in high-risk populations.[1-4,14-16]
- Nucleic acid amplification tests (NAATs) can improve accuracy of ano-genital ulcer diagnosis.[1,6,8,10,17]

Treatment pathways differ significantly. Accurate diagnostics will inform appropriate patient management and improve patient outcome.[6,10,18,19]

Syphilis infection rates increasing worldwide[2,3]

HSV-1 becoming more prevalent in genital infections[20,21]

1-3% genital lesions may be atypical zoster (VZV) presentations[18,22,23]

Infectious Agent	HSV-1 HSV-2	TP	VZV
Treatment	**Antiviral:** Aciclovir/Famciclovir/Valaciclovir*	**Antibiotics:** Benzathine penicillin*	**Antiviral:** recommended within 72hrs of symptoms**
Patient Management	**Counselling:** genital Type-1 has lower recurrence frequency / **Counselling:** genital Type-2 has higher recurrence frequency	**Partner notification:** Primary – past 90 days Secondary – past 2 years	**Partner notification:** Potential pain-management for Zoster-related neuralgia

Variations in patient management for different etiological agents of genital and oral lesions
** Based on IUSTI guidelines for management of HSV and Syphilis[6,9]*
***Based on EU guidelines for the management of Herpes Zoster[23]*

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