



**The Commonwealth of Massachusetts**  
Executive Office of Health and Human Services  
Department of Public Health  
Bureau of Infectious Disease and Laboratory Sciences  
305 South Street, Jamaica Plain, MA 02130

MAURA T. HEALEY  
Governor

KIMBERLEY DRISCOLL  
Lieutenant Governor

KATHLEEN E. WALSH  
Secretary

ROBERT GOLDSTEIN, MD, PhD  
Commissioner

Tel: 617-624-6000  
[www.mass.gov/doh](http://www.mass.gov/doh)

**Clinical Advisory February 10, 2025**  
**Increase Syphilis Screening in Massachusetts**

- Preliminary 2024 data indicate that 18 congenital syphilis cases occurred in Massachusetts, an increase of 29% compared to 2023. To stop congenital syphilis, syphilis screening should be broader and occur further upstream from pregnancy.
- Massachusetts Department of Public Health (DPH) recommends that clinicians provide syphilis screening and inform ALL sexually active persons, with special focus on:
  - Persons of reproductive potential and their sex partners,
  - Persons with a new sex partner or with STI/HIV acquisition in the prior year,
  - Persons with limited access to routine health care, including persons who are unhoused, have a history of incarceration, substance use or mental health disorders, or are newly arrived to Massachusetts from economically disadvantaged, high health burden areas.

## Background

Primary and secondary syphilis rates in Massachusetts have risen 61% over the past decade (from 6.2 to 9.9 cases per 100,000 population), though the rate now appears to have plateaued. From 2015 to 2024, rates increased 41% in males and 313% in persons of reproductive potential. In parallel, the number of congenital syphilis cases continued to increase in Massachusetts. In 2024, of the 18 reported congenital syphilis cases, there were two intrauterine fetal demises and one neonatal death.

Testing and treatment for syphilis during pregnancy dramatically decreases risk of congenital syphilis. Although 88% of potential congenital syphilis cases were averted through prompt diagnosis and treatment of pregnant persons and their partner(s) in Massachusetts, 78% (14/18) of congenital syphilis cases reported in 2024 were born to persons with late, limited, or no prenatal care.

## DPH Recommendations for Health Care Providers

### 1. Screen all sexually active persons of reproductive potential and their sex partners.

[The Centers for Disease Control and Prevention \(CDC\) recommends syphilis testing for reproductive age sexually active females and their sex partners, in order to reduce the rate of primary and secondary syphilis cases below the Healthy People 2030 goal of 4.6 per 100,000 among females aged 15-44 years.](#) The preliminary 2024 Massachusetts rate of primary and secondary syphilis in persons of reproductive potential aged 15-44 years is 6.2 per 100,000. DPH is therefore expanding screening recommendations to all sexually active persons of reproductive potential and their sex partners. Persons who do not have a regular health care provider or who have difficulty accessing testing services can be referred to [DPH Integrated Testing and Linkage Services](#).

### 2. Increase access to syphilis screening, treatment, and prevention in traditional and non-traditional health care settings.

[The United States Preventative Services Task Force \(USPSTF\) recommends routine screening for syphilis infection in persons who are at increased risk.](#) Massachusetts can be considered a

geographic area where sexually active adolescents and adults, regardless of gender or sexual orientation, are at increased risk of infection, because rates exceed Healthy People 2030 targets for primary and secondary syphilis. Screening for syphilis and for pregnancy at health care encounters, irrespective of setting (e.g., STI clinics, emergency departments and urgent cares, jail and prison intake, syringe services programs, and maternal and child health programs), is recommended to increase identification and treatment of persons with syphilis who have limited access to routine health care. DPH recommends the following:

- Implement opt-out screening for syphilis to reduce barriers to early diagnosis.
- Increase pregnancy screening in persons of reproductive potential to increase early entry into prenatal care.
- Link pregnant persons to early prenatal care. Barriers to early prenatal care, such as language barriers, substance use or mental health disorders, or misunderstandings about the purpose and urgency of prenatal care, should be addressed.
- Continue to recommend [doxycycline post exposure prophylaxis \(Doxo PEP\)](#) as part of STI prevention for cis-gender men who have sex with men, and transgender women who have a history of chlamydia, gonorrhea, or syphilis in the prior year; prescribe doxycycline ahead of episodic risk.
- Test for syphilis and HIV whenever a patient is diagnosed with another STI.

3. **Continue to screen all pregnant persons for syphilis at the first prenatal visit and during third trimester. Syphilis screening at delivery should be added for all pregnant persons with insufficient prior screening in pregnancy and for those at higher risk for infection, including**

- Persons with a new sex partner or with STI/HIV acquisition in the prior year,
- Persons with limited access to routine health care, including persons who are unhoused, have a history of incarceration, substance use or mental health disorders, or are newly arrived to Massachusetts from economically disadvantaged, high health burden areas.

The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening at the first prenatal care visit, followed by universal rescreening during the third trimester and at birth. However, screening at birth occurs too late to prevent neonatal syphilis exposure and is less likely to identify infection in those with prior negative syphilis screens during pregnancy. Hospital systems who consider their pregnant persons to be universally at high risk for syphilis acquisition during pregnancy may choose to implement universal syphilis screening at birth, in accordance with ACOG guidelines. Syphilis should always be considered whenever a pregnant person reports potential syphilis symptoms, new sex partners, or exposure. No infant should leave the hospital without the mother's serological status having been documented at least once during pregnancy.

Continue to contact the [DPH Division of STD Prevention](#) for:

- **Clinical consultation on complex cases**, available through the DPH Division of STD Prevention Clinical Team or the [STD Clinical Consultation Network](#). CDC syphilis treatment and partner management guidelines are available as an [app for Apple and Android devices](#).
- **Partner services** – contact tracing, exposure notification, and prevention counseling -- are automatically performed for new HIV infection, infectious syphilis cases, and cases of ceftriaxone non-susceptible gonorrhea. Record searches on prior syphilis test titers and treatment history documented in public health surveillance systems under U.S. jurisdiction are also available. Bicillin L-A® is also available, if you are unable to obtain the medication to treat patients with infectious syphilis or their contacts. For more information, call the [DPH Partner Services Program](#) Line at 617-983-6999.
- **Case reporting** - clinician-completed [DPH Syphilis Case Report Forms](#) are required for all syphilis cases, and provide details on clinical characteristics and treatment which are not automatically reported, unless your clinical organization participates in [ESP](#).