

Congenital Syphilis Case Investigation and Reporting Form Instructions

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Centers for Disease Control and Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of STD Prevention
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Congenital Syphilis Case Investigation and Reporting Form Instructions

Note: These instructions accompany the Congenital Syphilis Case Investigation and Reporting Form, CDC 73.126, REV. 02-2013.

This reporting form is authorized by law (Public Health Service Act, 42 USC 241, OMB Approval No. 0920-0128). Reporting of congenital syphilis cases using this form is required of all sexually transmitted disease (STD) project areas receiving STD grant funds from the Centers for Disease Control and Prevention (CDC).

Introduction

Congenital Syphilis Case Definition

Reported cases of congenital syphilis (CS) before 1989 were defined and classified on the basis of a complex set of clinical and serologic features known as the Kaufman criteria. These criteria were developed to help clinicians evaluate the likelihood that an infant or a child had CS. The need for clinical criteria came from the lack of a widely available “gold standard” test to confirm the diagnosis of CS. Serologic tests for syphilis (STS) alone are not useful for diagnosis. The Kaufman criteria, however, were not designed for use as a **surveillance case definition**.

CDC developed a **surveillance case definition** for CS in 1988 (subsequently revised in 1996). This **surveillance case definition** differs from the clinical diagnosis of congenital syphilis in several important ways. All infants born to mothers who have untreated or inadequately treated syphilis are considered potentially infected. (This criterion is based on the 70%-100% chance that during the first 4 years of infection, an untreated woman will transmit syphilis to her unborn baby.)* Asymptomatic infants and stillbirths are included in the case definition. The **surveillance case definition** makes case classification simpler, making comparisons across states and regions more reliable. Also, longitudinal follow-up is not required to determine the appropriate case classification, so reporting can occur in the immediate post-delivery period.

Another important feature of the **surveillance case definition** is its emphasis on the mother’s history of diagnosis, treatment, and follow-up. The cases defined by this **surveillance case definition** give program planners information on how to improve the STD prevention and prenatal care systems to identify and treat pregnant women who have syphilis. Having CS surveillance data available to program planners and managers improves our ability to reach high risk women and treat their syphilis infections early in pregnancy. The increased sensitivity of the **surveillance case definition** can classify infants as cases who are not infected with syphilis, reflecting the limitations of current diagnostic tests. Inclusion of these infants in the surveillance system is accepted, however, because they help identify problems in the prevention of CS. Nonetheless, the most recent revisions to the CS case report Form 126 were made with the intent of having reported cases more closely reflect the **surveillance case definition**.

*Thomas EW. Syphilis. New York: MacMillan Co., 1949

The Congenital Syphilis Case Investigation and Reporting Form

This form (CDC 73.126 REV. 02-2013) should be used by health officials who are responsible for identifying the infants or children of recently pregnant women who may be infected with *Treponema pallidum*. The accompanying algorithms (found on the back of the reporting form) are provided to **assist** in determining how a case of CS should be classified for reporting purposes. **The surveillance case definition remains the “gold standard” for CS case classification.** The surveillance case definition (appendix) should be used to classify cases into one of the following three surveillance categories: confirmed, probable, or syphilitic stillbirth.

Finding the Data on Cases of Congenital Syphilis

The information needed to determine whether an infant or a child meets the criteria for the CDC/Council for State and Territorial Epidemiology (CSTE) surveillance case definition of CS may be found in a variety of places:

- The mother’s syphilis reactor file
- The mother’s hospital record
- The infant’s or child’s hospital record
- The infant’s or child’s birth certificate or death certificate

No single record is likely to contain all the information needed; therefore, information should be obtained from several sources. For example, the following steps may be taken to evaluate a report of a reactive STS obtained at delivery:

- Check the STD program’s reactor file to determine whether the mother had evidence of untreated or inadequately treated syphilis before delivery.
- Review the mother’s hospital and prenatal records for demographic information, prenatal care information, findings at delivery (e.g., genital lesions, abnormal placenta, or stillborn infant), and serologic test results.
- Review the infant’s or child’s medical record for physical examination findings, radiographic, serologic, cerebrospinal fluid (CSF), other test results, and treatment information.

If an STS on the mother or infant at delivery is not routinely performed in hospitals, identifying cases that meet the surveillance definition of CS will be more difficult.* Case detection can be augmented by:

- Asking all women who are treated for syphilis whether they have been pregnant during the last 12 months and asking about the outcome of the pregnancy.
- Comparing fetal death records with the reactor file on a routine basis to identify possible syphilitic stillbirths.

Health officials responsible for investigating cases of CS should establish working relationships with hospitals having obstetrical services, prenatal clinics, and other providers of health care to pregnant women and infants to ensure access to all of these records.

Data for case classification should be available at the time of delivery. Sequential infant titers are not required for determining whether an infant or a stillborn meets the surveillance case definition of CS. The results of sequential infant titers do not have any bearing on the case classification process for surveillance purposes.

Detecting cases of CS is an active process. Someone in the STD prevention program should be trained to collect the data necessary for completing this form. In areas where numerous case investigations take place, it may be beneficial to request the assistance of the hospital's infection control nurse, obstetricians, midwives, or pediatricians to provide some of the information needed to complete the case investigation.

Some data required on the reporting form may not be found on the aforementioned records. Names of cities, counties, states, and countries should be entered on the reporting form as numeric codes called FIPS (Federal Information Processing Standards) codes. For details on ordering the complete Worldwide Geographic Location Codes, call (202) 219-0077 or search for "Geographic codes" box on website WWW.GSA.GOV.FIPS. Codes should be available for all health care workers responsible for completing these forms. To order copies of the Congenital Syphilis Case Investigation and Reporting Form (CDC 73.126) and/or Instruction booklets contact the Surveillance and Data Management Branch, Division of STD Prevention, NCHHSTP, CDC, (404) 639-8356.

*In high syphilis incidence areas, obtaining a STS on every mother or infant at delivery is an important case detection strategy. If this policy is not in place, STD prevention programs should work closely with delivery hospitals to help implement this policy.

Quality Assurance

Read the instructions, the footnotes, and the algorithm carefully before attempting to complete this form. Before these forms are sent by the local reporting areas to the state health department or state STD program, they should be checked for completeness and accuracy by someone familiar with the revised 73.126 (02-2013) form and instructions. Errors and omissions should be corrected before the form is sent to the state. Similarly, the state STD program should assign someone the responsibility of checking forms for completeness and accuracy before sending them to CDC. Reporting areas with errors or omissions will be contacted for correct information. The second (blue) sheet of the triplicate form should be sent to CDC. Photocopies must have a unique ID and should not include the top portion (personal identifiers) of the form.

Individual reports should be sent as soon as possible after the case has been reported to the health department. However, completed forms may be sent as batches to CDC monthly. Morbidity is counted based on the infant's birth date and the mother's residence. Health departments will be given sufficient advance notice of year-end close-out dates.

Electronic Reporting of Cases

Many states are capable of transmitting the information on the reporting form to CDC electronically through the National Electronic Telecommunications System for Surveillance (NETSS). The reporting form has been designed to be compatible with NETSS to facilitate this method of reporting. Specific instructions for reporting all STD data, including CS data, through NETSS is available through the Surveillance and Data Management Branch, (404) 639-8356.

Updating Information on a Case Already Reported to CDC

To avoid the possibility of duplicate reporting, do not complete a new form to update information on a case that has already been reported to CDC. Similarly, do not send a photocopy of the original form. Call the Surveillance and Data Management Branch (404) 639-8356 regarding any corrections to be made. Methods for updating or correcting cases sent electronically via NETSS will be provided in the NETSS instructions.

Obtaining Training and In-Service Materials

To accurately carry out a case investigation and complete the CS case investigation and reporting form requires some epidemiologic and clinical knowledge of CS. The following is a list of recent CDC publications that describe CS, its diagnosis, and treatment. These publications can be ordered by calling the Information Services Office, NCHHSTP/OD, at (404) 639-8063.

Publications

1. Centers for Disease Control and Prevention. Congenital syphilis — United States, 2000. *Morbidity and Mortality Weekly Report* 2001; 50:573-7.
2. Centers for Disease Control and Prevention. Evaluation of Congenital Syphilis Surveillance System, New Jersey, 1993. *Morbidity and Mortality Weekly Report* 1995; 44:225-227.
3. Centers for Disease Control and Prevention. Primary and secondary syphilis — United States, 1998. *Morbidity and Mortality Weekly Report* 1999; 48:873-878.
4. Finelli L, Crayne EM, Spitalny KC. Treatment of infants with reactive syphilis serology, New Jersey: 1992-1996. *Pediatrics* 1998; 102:1-6.
5. Centers for Disease Control and Prevention. Epidemic of congenital syphilis — Baltimore, 1996-1997. *Morbidity and Mortality Weekly Report* 1998; 42:904-907.
6. Sanchez PJ. Laboratory tests for congenital syphilis. *Pediatric Infectious Disease Journal* 1998; 17(1):70-71.
7. Stoll BJ. Congenital syphilis: evaluation and management of neonates born to mothers with reactive serologic tests for syphilis. *Pediatric Infectious Disease Journal* 1994;13(10):845-852.
8. Mascola L, et al. Inadequate treatment of syphilis in pregnancy. *Am J Obstet Gynecol* 150:945-47, 1984.
9. Ehling LR. Control and prevention of congenital syphilis. *Border Health* 5(2):11-13, 1989.
10. Zenker P, Berman S. Congenital syphilis: reporting and reality. *Am J Public Health* 80:271-72, 1990.
11. Cohen DA, et al. The effects of case definition, maternal screening, and reporting criteria on rates of congenital syphilis. *Am J Public Health* 80:316-17, 1990.
12. Dunn RA, Webster LA, Nakashima AK, Sylvester GC. Surveillance for Geographic and Secular Trends in Congenital Syphilis -United States, 1983-1991, *MMWR* Vol 42, No.55-56.
13. CDC. Guidelines for prevention and control of congenital syphilis. *MMWR* 1988; 37(No. S-1).
14. Thompson B, et al. Congenital Syphilis in Maryland: 1986-1991: The Effect of Changing the Case Definition and Opportunities for Prevention. *Sexually Transmitted Disease* 22(6):364-369, 1995.
15. Coles BF, Hipp SS, Silberstein GS, Chen JH. Congenital syphilis surveillance in upstate New York, 1989-1992: implications for prevention and clinical management. *J Infect Dis* 1995;171:732-5.
16. Risser WL, Hwang LY. Problems in the current case definitions of congenital syphilis. *JPediatr* 1996; 129:499-505.

17. CDC. *Sexually transmitted disease surveillance, 2001*. Atlanta, Georgia:U.S.Department of Health and Human Services, Centers for Disease Control and Prevention, September 2002.
18. CDC. *Syphilis Surveillance Supplement, 2001*. Atlanta, Georgia:U.S.Department of Health and Human Services, Centers for Disease Control and Prevention, February 2003.
19. CDC. Sexually transmitted diseases treatment guidelines, 2002. *MMWR* 2002;51(RR-6): 1-80.
20. Gust DA, Levine WC, St Louis ME, Braxton J, Berman SM. Mortality associated with congenital syphilis in the United States, 1992-1998. *Pediatrics* 2002;109:E79-9.
21. Martin D, Bertrand J, McKegney C, Thompson L, Belongia E, Mills W. Congenital syphilis surveillance and newborn evaluation in a low-incidence state. *Arch Pediatr Adolesc Med* 2001;155:140-4.
22. CDC. Case definitions for infectious conditions under public health surveillance. *MMWR Recomm Rep*. 1997 May 2;46(RR-10):1-55.

General Instructions

1. Use a pencil or ballpoint pen to complete forms. Avoid felt tip markers since they result in poor copies.
2. Avoid stacking forms when writing on them; this practice results in extraneous marks on copies, making them illegible.
3. Fill in one digit per dashed line.
4. Mark only one box per question.
5. Boxes should preferably be marked with an X.
6. Dates should be written in MM/DD/YYYY format. Months and days less than 10 should be preceded with a zero (0). For example, May should be recorded as 05. If the day is not known, record the known month and year values and record the day as 15. If the entire date is unknown, mark the *unknown* box with an X.
7. On all questions, unknowns should be marked with an X in the *unknown (unk)* box.
8. Do not write in more dates than there are places to write in dates. These dates will be disregarded at CDC.
9. Do not write additional information in the margins or spaces. This information will be disregarded at CDC. For example, if a test result is pending, indicate that the result is unknown. Do not write *pending* in the margin.
10. Skip patterns are directions that appear in bold italic print next to some answers (***Go to Q...***) and direct you to the next question to be answered. Observe these directions and do not complete a question that you have been directed to skip. Data entered where an item should have been skipped will be disregarded at CDC.
11. Except for skip patterns and where specifically mentioned in these instructions, all questions must be completed. Reporting areas with missing data will be contacted for correct information.
12. Footnotes mentioned in these instructions and on the reporting form are located on the back of each form.

Reporting Form Items

Other geographic unit: The geographic unit is an optional code such as a census tract identifier or the last three digits of the zip code which would be useful to the health department. Leave this answer blank if there is no geographic unit.

Case ID No.: The case identification number is a red preprinted number assigned to each case by CDC.

Local Use ID No.: The local use identification number is an identification number assigned to the case by the local or state health department for internal use. Completion of this item is optional.

NOTE: Please fill in all fields. If data are unknown, please check the “*unknown*” (unk) box provided with the data element, or code as instructed or that particular data element.

Part I. Maternal Information

1. Report Date to Health Department: This is the date when the first information about the infant or child came to the attention of the health department or STD program. This field should never be blank. If the date is not known, mark the *unknown* box. The report date should never be before the infant’s delivery date.
- 2–3. Reporting State FIPS code, Reporting County FIPS code: Federal Information Processing Standards (FIPS) codes are assigned for each state and county in the United States. State FIPS codes are 2-digit numbers and county FIPS codes are 3-digit numbers. Every locality has assigned FIPS codes with one exception: U. S. territories do not have assigned county FIPS codes. For the purposes of completing this form, U. S. territories should use county FIPS code 001 and write *no county* next to this code. The full name of the state and county should be written on the line next to each FIPS code. (See the Finding the Data on Cases of Congenital Syphilis for instructions on how to obtain FIPS code listings.)

The reporting state and county are where the case report originates. This information should never be marked unknown. A case may be investigated in one locality but reported by another. In most instances, the patient’s residence is chosen as the reporting locality; however, no guidelines exist for designating the reporting locality. To optimize national reporting, each area should have a consistent procedure for avoiding reports from both places.

4. Mother’s state FIPS code: This code should correspond to the state of residence of the mother. Residence FIPS codes may be different from the FIPS codes of the reporting health department. (See instructions for completing the reporting FIPS codes.)
5. Country of residence: This code should correspond to the country of residence of the mother. It should be left blank if the mother's residence is in the U. S. For foreign countries of residence, enter the 2-digit country code (i.e., CH for China, MX for Mexico, RS for Russia). For other country codes, contact the SDMB in the Division of STD Prevention at (404) 639-8356.
6. Mother’s residence county FIPS code: This code should correspond to county of residence of the mother. Residence FIPS codes may be different from the FIPS codes of the reporting health department. (See instructions for completing the reporting FIPS codes.)
7. Mother’s residence ZIP code: Write the zip code of mother’s residence. If the zip code is not known, mark the *unknown* box.
8. Mother’s date of birth: Write the mother’s date of birth. If this date is not known, mark the *unknown* box.
9. Mother’s obstetric history: Write the number of times the mother has been pregnant (G) and how many times the mother delivered a live infant (P). Two spaces have been provided in case the mother has had more than 9 pregnancies. Elective terminations (abortions) and stillbirths would count as pregnancies, but not as deliveries of live births. If mother’s obstetric history is not available, enter “99” for both G and P.

10. Last menstrual period (LMP) (before delivery): Show the date of onset of the last menstrual period before delivery. Do not leave this field blank. If the LMP is not known, mark the *unknown* box. If the day is not known, record the known month and year values and record the day as 15, per General Instruction 6. (see p. 8).
11. Date of first prenatal visit:
 - a) Show the date of the first prenatal visit; do not leave this field blank. If the mother received no prenatal care, mark the “*No prenatal care*” box and go to **Q12**. If the date is unknown, mark the “*unknown*” box and go to **Q11b** and mark the trimester of the first prenatal visit if the mother did have prenatal care.
 - b) Check the box that matches the trimester of the mother’s first prenatal visit. If the prenatal visit is unknown, mark the “*unknown*” box.
12. Mother’s ethnicity: Mark the appropriate box to denote the mother’s ethnicity (Hispanic/Latino or Non-Hispanic/Latino). Do not leave this field blank. If mother’s ethnicity is not known, mark the “*unknown*” box.
13. Mother’s race: Mark all that apply to denote the mother’s race: If the mother’s race is not known, mark the “*unknown*” box.
14. Did mother have non-treponemal or treponemal tests at:
 - a) Indicate if mother had non-treponemal or treponemal tests at her first prenatal visit. If unknown, mark the “*unk*” box.
 - b) Indicate if mother had non-treponemal or treponemal tests at 28–32 weeks gestation. If unknown, mark the “*unk*” box.
 - c) Indicate if mother had non-treponemal or treponemal tests at delivery. If unknown, mark the “*unk*” box.
15. Mother’s marital status: Mark the appropriate box to show the mother’s current marital status. Do not leave this field blank. If the marital status is not known, mark the “*unknown*” box.
16. Indicate, during pregnancy and delivery, dates and results of **non-treponemal** tests:
 - a) Write the date of mother’s non-treponemal test at delivery (or closest to it) during the pregnancy of the potential case of CS being reported. If the date is unknown, mark the “*unknown*” box. Mark the box that indicates if the test result was reactive or nonreactive; if the result is unknown, mark the “*unknown*” box. If reactive, fill in titers in spaces provided beginning *immediately to the right of the colon*. For example, a titer of 1:8 is recorded 1:8_ _ _ . Do *not* fill in the remaining spaces. Rewriting a 1: is not necessary. If titer is unknown, write “9999”. If titer exceeds 4 digits, write “8192” (the highest serial dilution with 4 digits). If the titer is weakly reactive then enter (o) zero.
 - b) Write the date of mother’s first non-treponemal test for this pregnancy; fill as described for part a).

NOTE: Every date entered in question 16 must have a result. Do not enter a result without a date. If there is a titer, then there must be a response for the date and the result.

17. Indicate, during pregnancy and delivery, date, type, and result of **treponemal** test:
- Write the date of mother's first treponemal test during the pregnancy of the potential case of CS being reported. If the first treponemal test was at delivery, list it as the first treponemal test (instead of the test closest to delivery). If the date is unknown, mark the "unk" box. Mark the box that indicates what type of treponemal test (EIA, TP-PA, etc.) was used; if the test type is unknown, mark the "unk" box. Mark the box that indicates if the test result was reactive or nonreactive; if the result is unknown, mark the "unk" box.
 - Write the date of mother's most recent (e.g., closest to delivery) treponemal test; fill as described for part a).

NOTE: Every date entered in question 17 must have a result. Do not enter a result without a date. If there is a titer, then there must be a response for the date and the test type.

18. What was mother's HIV status during pregnancy?: **Please note: a medically documented test result for HIV status is preferred in answering this question;** if a medically documented test result is not available, use the mother's responses. If positive, mark the box labeled "P". If negative, mark the box labeled "N". If the result was equivocal, mark the box labeled "E". If the mother was asked, and she did not know her HIV test result, and no further information is available, mark the box labeled "U". If the mother was asked, and she stated she has not yet been tested for HIV, and no further information is available, mark the box labeled "X".
19. What **CLINICAL** stage of syphilis did mother have during pregnancy?: Mark the box that matches the stage of syphilis with which a medical provider diagnosed the mother. If the mother is diagnosed as being "serofast" or having been previously treated for syphilis, mark the box labeled "previously treated/serofast". If the mother is diagnosed with "syphilis" without stage specified, mark the box labeled "Other". If the stage of syphilis with which a medical provider diagnosed the mother is not known or available, mark the box labeled "unk".
20. What **SURVEILLANCE** stage of syphilis did mother have during pregnancy?: Mark the box that matches the surveillance case definition that best defines the mother's stage of syphilis based upon available information. If not enough information is available to match a surveillance case definition, mark the box labeled "Other". If no information is available to match a surveillance case definition, mark the box labeled "unk".
21. When did mother receive her first dose of benzathine penicillin?: Write the date the mother received her first dose of benzathine penicillin. If the mother's first dose of benzathine penicillin was before the pregnancy of the potential case of CS being reported, mark the box labeled "Before pregnancy". If mother's first dose was during 1st, 2nd, or 3rd trimester, mark the box that matches the trimester. If the date is unknown or mother was treated with an antibiotic other than benzathine penicillin, mark the box labeled "unk" and go to **Q22**. If mother received no treatment for syphilis, mark the box labeled "No Treatment" and go to **Q24**.
22. What was mother's treatment?: Mark the box matching mother's total dose of benzathine penicillin. If mother was treated with an antibiotic other than benzathine penicillin, mark the box labeled "Other". If the antibiotic with which mother was treated is unknown, mark the box labeled "unk".
23. Did mother have an appropriate serologic response?: Refer to Footnote B: if mother had a 4-fold or greater decrease in nontreponemal titer by 6–12 months after treatment for primary or secondary syphilis, or by 12–24 months for latent syphilis (early, late, or of unknown duration), mark the box labeled "Yes, appropriate response". If mother demonstrated a 4-fold or greater increase in nontreponemal titer or otherwise showed symptoms of syphilis (e.g.,

chancere) after treatment, mark the box labeled “No, inappropriate response: evidence of treatment failure or reinfection”. If titer changed less than 4-fold, or not enough data are available (e.g., only pre-treatment titer available), mark the box labeled “Response could not be determined from available non-treponemal titer information”. If no titers are available 3 or more months after treatment, mark the box labeled “Not enough time for titer to change”.

Part II. Infant Information

24. Date of delivery: Write the date of delivery of the infant/child (infant’s/child’s birthdate). Do not leave this field blank.
25. Vital status: Show the vital status of the infant/child at the time of this case report and investigation. Do not leave this field blank. If the infant or child is alive, proceed to question 27. If the infant or child was born alive then died, proceed to question 26. If the infant was stillborn (see Footnote C for definition of a stillbirth), proceed to question 27. If the vital status is not known, proceed to question 27.
26. Indicate date of death: Complete this question *only* if the infant/child died after birth. If the date of death is not known, mark the “unk” box. Do not complete this question if the infant was stillborn.
27. Birthweight: Write the birth weight in *grams*, not pounds and ounces or kilograms. Do not use decimal points. Write a 0 in the first space if the infant weighed less than 1000 grams. For example, a birth weight of 750 grams should be written as 0 7 5 0. If the hospital recorded the weight in pounds and ounces, convert the weight to grams using the formula: 1 pound = 454 grams, 1 ounce = 28 grams. For example, a birth weight of 6 pounds, 11 ounces = 3,032 grams. If the weight is listed in kilograms, multiply kilograms x 1000 = grams. For example, 2.5 kilograms = 2500 grams. Do not leave this field blank. If the response is not known, mark the “unk” box.
28. Estimated gestational age (EGA): Show the gestational age in *weeks*. If a fraction of a week is also recorded, round the gestational age to the nearest whole number. Round down fractions of 3/7 or less; round up fractions of 4/7 or more. For example, 40 2/7 weeks should be recorded as 40. Gestational age is usually available in the delivery record or can be calculated from the maternal due date. The Dubowitz exam (done by hospital staff) or sonogram results are acceptable if the LMP or the due date is not recorded. If the infant is called term without a specified number of weeks, LMP, or due date, then show the estimated gestational age as 40. Do not leave this field blank. If the gestational age is not known, mark the “unk” box.

*NOTE: If the infant was stillborn, proceed to **Question 37**. Do not answer questions 29–36.*

29. Did infant/child have a reactive **non-treponemal test** for syphilis?: (e.g., VDRL, RPR)
- a) Mark the appropriate box to show whether the infant/child has had *any* reactive non-treponemal tests for syphilis at any time. Cord blood tests are included as infant serologic tests for syphilis. Do not leave this field blank (unless the infant was stillborn). If the answer to this question is “no”, “no test”, or “unknown”, proceed to question 30. If the answer to this question is “yes”, fill in:
- b) *the date and*
- c) *the titer of the infant/child’s first reactive non-treponemal test for syphilis. For titer, fill in the spaces beginning immediately to the right of the colon. For example, a titer of 1:8 is recorded 1:8 _ _ _ . Do not fill in the remaining spaces with 9s or 0s. Rewriting a 1: is not*

necessary. If titer exceeds 4 digits, write "8192" (the highest serial dilution with 4 digits). If the titer is unknown, write "9999". If the titer is weakly reactive then enter (o) zero.

30. Did infant/child have a reactive **treponemal** test for syphilis?: (see Footnote D for details)
- a) Mark the appropriate box to show whether the infant/child has had any reactive **treponemal** tests for syphilis at any time. Cord blood tests are included as infant serologic tests for syphilis. Do not leave this field blank (unless the infant was stillborn). If the answer to this question is "no", "no test", or "unknown", proceed to question 31. If the answer to this question is "yes", fill in:
 - b) *the date* of the infant/child's first reactive treponemal test for syphilis.
31. Did the infant/child, placenta, or cord have a darkfield exam, DFA, or special stains?: Mark the appropriate box to show whether a darkfield examination, DFA-TP, or special stain was done and the result. *Please note: The DFA-TP is not the FTA-ABS. A DFA test is performed on lesion material using a fluorescent stain for T. pallidum; it is not a serologic test.* Do not leave this field blank (unless the infant was stillborn). If the result of the darkfield or DFA-TP examination is not known or it is not known whether a darkfield or DFA-TP examination was done, mark the "unk" box.
32. Did the infant/child have any signs of CS? (check all that apply): Refer to Footnote E for a list of "classic" signs of CS. If physical exam was normal, check "no signs/asymptomatic". If no information is available, check "unk".
33. Did the infant/child have long bone X-rays?: Mark the appropriate box to show whether long bone X-rays were done and the results. Evidence of osteochondritis or periostitis is consistent with CS. Do not leave this field blank (unless the infant was stillborn). If the results of the long bone X-rays are not known or it is not known whether long bone X-rays were done, mark the "unk" box.
34. Did the infant/child have a CSF (cerebrospinal fluid) VDRL?: Mark the appropriate box to show whether a CSF-VDRL was done and the results. Do not leave this field blank (unless the infant was stillborn). If the result of the CSF-VDRL is not known or it is not known whether a CSF VDRL was done, mark the "unk" box.
35. Did the infant/child have a CSF WBC (white blood cell) count or CSF protein test?: (See Footnote F for a discussion of normal and abnormal CSF WBC count and CSF protein). Mark the appropriate box to show whether a CSF WBC count and/or CSF protein test were done, and the results. Note that results are recorded as "elevated" or "not elevated". Do not leave this field blank (unless the infant was stillborn). If the results of the CSF WBC count and CSF protein test are not known, or it is not known whether the CSF WBC count and protein were done, mark the "unk" box.
36. Was the infant/child treated?: Mark the appropriate box to show whether treatment was given and what was administered. Mark box 1 if aqueous or procaine penicillin or some combination of the two was administered at the recommended dose for 10 or more days. Previously, box 2 referred to treatment with ampicillin (usually in combination with an aminoglycoside or cephalosporin for broad spectrum coverage) and then was switching to either aqueous or procaine penicillin or a combination to complete at least 10 days of therapy. This treatment is no longer recommended and is thus obsolete. Mark box 3 if the infant/child was treated once with

benzathine penicillin G, 50,000 units/kg IM. Mark box 4 if a treatment other than the treatments designated in boxes 1 or 3 was given; for example, 10 days of ampicillin or ceftriaxone, or other than the recommended dose or duration of penicillin. Mark box 5 if the infant/child did not receive therapy. Mark box 9 if the type or the duration of treatment is not known or if it is not known whether treatment was given at all.

Part III. Congenital Syphilis Case Classification

37. Classification: For assistance in making a case classification, see the surveillance case definition (appendix) and algorithms (decision tree) on the back of the triplicate form of the Case Investigation and Reporting Form. Mark the appropriate box to show the classification: not a case, a confirmed case, a syphilitic stillbirth, or a probable case. Do not leave this field blank.

Appendix

Surveillance Case Definition for Congenital Syphilis

A **confirmed case** of congenital syphilis is an infant or child in whom **Treponema pallidum** is identified by darkfield microscopy, direct fluorescent antibody, or other specific stains in specimens from lesions, placenta, umbilical cord, or autopsy material.

A **probable case** of congenital syphilis is either of the following:

- A. any infant whose mother had untreated or inadequately treated¹ syphilis at the time of delivery, regardless of the findings in the infant or child;
- B. any infant or child who has a reactive treponemal test for syphilis and any one of the following:
 1. evidence of congenital syphilis on physical examination²;
 2. evidence of congenital syphilis on long bone X-ray;
 3. reactive cerebrospinal fluid CSF-VDRL;
 4. elevated CSF WBC count or CSF protein (without other cause)³ ;
 5. reactive test for IgM antibody⁴.

A **syphilitic stillbirth** is defined as a fetal death in which the mother had untreated or inadequately treated syphilis at the time of delivery of a fetus after a 20-week gestation or of a fetus weighing >500g.

¹Inadequate treatment consists of any non-penicillin therapy or penicillin given less than 30 days before delivery.

²Signs of CS in an infant or a child younger than 2 years of age may include condyloma lata, snuffles, syphilitic skin rash, hepatosplenomegaly, jaundice due to syphilitic hepatitis, pseudoparalysis, or edema from nephrotic syndrome or malnutrition. Stigmata in an older child may include interstitial keratitis, nerve deafness, anterior bowing of shins, frontal bossing, mulberry molars, Hutchinson's teeth, saddle nose, rhagades or Clutton's joints.

³In the immediate newborn period, interpretation of these tests may be difficult; normal values differ with gestational age and are higher in preterm infants. As general guidelines, during the first 30 days of life, a CSF WBC count of > 15 WBC/mm³ or a CSF protein >120 mg/dl is abnormal. After the first 30 days of life, a CSF WBC count of >5 WBC/mm³ or a CSF protein >40 mg/dl is abnormal, regardless of serology. However, determination of elevated CSF parameters should be made in consultation with the treating physician of the case in question.

⁴A treponemal test that detects a specific subunit of antitreponemal IgM. This test is not yet widely available and should not be confused with FTA-ABS.