## Screening for Syphilis Infection in Pregnancy: Clinical Summary of a U.S. Preventive Services Task Force Recommendation

### Population

<table>
<thead>
<tr>
<th>All Pregnant Women</th>
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### Recommendation

Screen for syphilis infection.

**Grade: A**

### Screening Tests

Nontreponemal tests commonly used for initial screening include:

- Venereal Disease Research Laboratory (VDRL)
- Rapid plasma reagin (RPR)

Confirmatory tests include:

- Fluorescent treponemal antibody absorbed (FTA-ABS)
- *Treponema pallidum* particle agglutination (TPPA)

### Timing of Screening

Test all pregnant women at the first prenatal visit.

### Other Clinical Considerations

Most organizations recommend testing high-risk women again during the third trimester and at delivery.

Groups at increased risk include:

- Uninsured women
- Women living in poverty
- Sex workers
- Illicit drug users
- Those with other sexually transmitted diseases (STDs)
- Other women living in communities with high syphilis morbidity

Prevalence is higher in the southern United States, in metropolitan areas, and in Hispanic and African-American populations.

### Interventions

The Centers for Disease Control and Prevention (CDC) recommends treatment with parenteral benzathine penicillin G.

Women with penicillin allergies should be desensitized and treated with penicillin.

Consult the CDC for the most up-to-date recommendations: [www.cdc.gov/std/treatment/](http://www.cdc.gov/std/treatment/).

### Relevant USPSTF Recommendations

Recommendations on screening for other STDs, and on counseling for STDs, can be found at [www.preventiveservices.ahrq.gov](http://www.preventiveservices.ahrq.gov).

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**USPSTF** = U.S. Preventive Services Task Force.
### Table 1. What the USPSTF Grades Mean and Suggestions for Practice

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer/provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
<td>Offer/provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.</td>
<td>Offer/provide this service only if other considerations support offering or providing the service in an individual patient.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
<td>Discourage the use of this service.</td>
</tr>
<tr>
<td>I statement</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
<td>Read the clinical considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.</td>
</tr>
</tbody>
</table>

USPSTF = U.S. Preventive Services Task Force.

### Table 2. U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit

<table>
<thead>
<tr>
<th>Level of Certainty*</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>High</td>
<td>The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</td>
</tr>
<tr>
<td>Moderate</td>
<td>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies, inconsistency of findings across individual studies, limited generalizability of findings to routine primary care practice, lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</td>
</tr>
<tr>
<td>Low</td>
<td>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies, important flaws in study design or methods, inconsistency of findings across individual studies, gaps in the chain of evidence, findings that are not generalizable to routine primary care practice, a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.</td>
</tr>
</tbody>
</table>

* The U.S. Preventive Services Task Force (USPSTF) defines certainty as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.