MNPQC

PERINATAL EDUCATION ECHO SERIES

AUGUST 27, 2026 | SESSION SNAPSHOT

Congenital Syphilis on the Rise: Closing the Gap Through Universal Screening, Early Treatment, and Accessible Care

SESSION SUMMARY

This session focused on the rising rate of congenital syphilis in Minnesota and examined gaps in prenatal care, testing, treatment, and systemic barriers that contribute to preventable outcomes. Participants explored practical, evidence-based strategies for universal screening, early diagnosis, and compassionate, non-stigmatizing care across perinatal and other healthcare settings.

UNDERSTANDING THE LANDSCAPE OF CONGENITAL SYPHILIS:

Nationally:

- **4,000 newborns** were affected in the U.S. in 2024, which is the **12th consecutive annual increase**.
- **88% of U.S. cases** involved a missed testing or treatment opportunity.
- **Infections without symptoms among women rose 8% in 2024**, highlighting that the rise in cases is less about recognizing symptoms and more about improving screening.

Source: CDC STI Surveillance 2024 (Provisional), Sept 24 2025 | CIDRAP, Sept 24 2025

In Minnesota: 30 cases were reported in 2025, **which is about 1 case for every 2,037 live births.** This a significant increase from 2016, when there was approximately **1 case for every 9,804 live births.**

Source: CDC STI Surveillance 2024 (Provisional) | MDH CS Enhanced Surveillance 2023–2025

Why this matters: Minnesota's trends mirror national trends, showing the gap isn't closing.

WHERE IS THE GAP IN PRACTICE?

- The Centers for Disease Control and Prevention (CDC) recommends screening pregnant patients **three times**: at the first prenatal visit, between 28–32 weeks, and at delivery.
- The procedures are in place, but access remains a challenge. Barriers such as transportation, mistrust, trauma, and insurance can prevent patients from attending prenatal visits.
- A recent Minnesota report found that **31 of 85 mothers who tested positive for syphilis received no prenatal care.** Of the 85 mothers reviewed, **only 11 were treated in the first or second trimester.**

Source: MDH CS Enhanced Surveillance 2023–2025 | McDonald et al. MMWR 2023;72(46):1269–1274

Updated as of August 2026

CASE STUDY SUMMARY

- **Visit 1:** An uninsured patient visits a rural emergency department with abdominal cramping and tests positive for syphilis. Due to limited resources, the results were not available until after discharge. The provider had no way to reach the patient by phone to report the case.
- **Visit 2:** Weeks later, now pregnant, the patient tests positive again at another facility. The first test results were never reported to the health department, and the second positive result was again not available until after discharge.
- **Visit 3:** At 32 weeks, the patient tests positive again. Treatment begins, but it is too late to prevent congenital syphilis.

Three healthcare visits. Three positive tests. Two missed opportunities to treat before delivery.

KEY RECOMMENDATIONS:

1 Move Toward Universal Screening:

- **Risk-based screening** leaves room for provider judgment, and clinical signs are often absent.
- **Universal Screening** eliminates selection bias, and providers are already performing a series of universal screenings in the prenatal setting.

2 Meet People Where They Are:

Partner with Community Health Workers to meet patients in the community, use every emergency department visit as a screening opportunity, and test every person for syphilis, especially those of reproductive age.

3 Widen the Net:

Syphilis has shared risk pathways with other conditions, highlighting the importance of using the same visit to perform rapid tests on HIV, HBV, and HCV, further preventing negative outcomes.

4 Reconsider Fixed Per-Patient Payments:

Prenatal prevention can reduce costs: $100–$200 for testing and treatment versus costly intensive care when congenital syphilis causes newborn complications, including NICU stays.

Source: Umapathi KK et al. Pediatr Infect Dis J. 2019 | Staneva M et al. Emerg Infect Dis. 2023;29(10)

RESOURCES:

- **Minnesota Department of Health (MDH), Syphilis Information:** This **webpage** from MDH walks through general information regarding syphilis and congenital syphilis. This includes resources for health professionals to promote prevention, screening, treatment, and reporting, along with key disease statistics.
- **CDC's Sexually Transmitted Infections Treatment Guidelines (2021) on Syphilis**: Find resources **here** related to the various syphilis stages with key recommendations on treatment and follow-up.
- **Minnesota's Disease Intervention Specialists (DIS):** Provides confidential, free support to patients to access healthcare to test partners through the Minnesota Department of Health **STI/HIV Partner Services Program**.
- **Vital Signs: Missed Opportunities for Preventing Congenital Syphilis - United States, 2022:** This study, available for free, found that most congenital syphilis cases in the U.S. were linked to missed opportunities for testing or treatment during pregnancy, highlighting the importance of timely prenatal screening and treatment to prevent congenital syphilis. Access Link: **https://pmc.ncbi.nlm.nih.gov/articles/PMC10684351/**

Frequently Asked Questions & Answers:

- **Q:** What are the barriers to having Community Health Workers (CHWs) administer the shot in the field?
  - **A:** It depends on the CHW's role, qualifications, and what the state allows. Emergency medical responders can already administer the injection, but expanding this to CHWs would require the right training, qualifications, and state approval. Trusted community sites, such as family medicine practices and community clinics, could also be a good option. For some patients, having a neutral, familiar place to receive care can make a big difference.
- **Q:** Why does congenital syphilis or stillbirth occur despite syphilis treatment early in pregnancy?
  - **A:** There are two main reasons: 1) Treatment wasn't fully completed. Patients may face barriers like transportation, child care, or difficulty returning for their next dose. If treatment is interrupted, they may have to start over. This happens about 20% of the time—roughly 1 in 5 cases. 2) Reinfection happens. A patient can be successfully treated and then become infected again. In 2022, about 10% of reported cases were reinfections, which is why testing at delivery is still important.

PRESENTER CONTACT

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ADDITIONAL DETAILS

If you have questions about this session snapshot or would like to request access to the session slides, please contact the QI Team: QI@minnesotaperinatal.org.

Learn more about this ECHO Series. Visit our ECHO webpage.

Updated as of August 2026