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From the Secretary/Treasurer Sarah McCullough, MD, FACEP

Syphilis...It is Back

In 1999 the Center for Disease Control (CDC) launched a plan to eliminate syphilis from the US. In 2000, the rate of primary and secondary syphilis was the lowest since reporting began in 1941. It was 2.1 cases / 100,000 population. Rates have been on the rise since that time and the number of cases in 2012-2013 was 18 cases/100,000.

Syphilis is a curable sexually transmitted disease caused by *Treponema palladium*. We need to be aware of the signs and symptoms so that proper testing is done to make the diagnosis, then treat the disease. If not, the spread of syphilis will continue and long-term consequences of the disease will ensue. So here is a quick review.

Syphilis is transmitted by contact with active lesions of a sexual partner or can be transmitted from an infected pregnant woman to her fetus or infant. The disease is a chronic systemic infection with periods of active disease and periods of latency. Those with untreated disease go through 4 overlapping stages; primary, secondary, latency, and tertiary. The initial 2 stages are

the most infectious.

Primary syphilis is characterized by a painless, indurated ulcer (chancre) at the site of inoculation. This is generally the genital, anal, or oral mucosa. It is accompanied by moderate regional lymphadenopathy. Incubation period is around 21 days, but can be 2-6 weeks. The chancre heals spontaneously. Some of the treponemes disseminate to multiple organs and cause chronic disease.

Secondary syphilis occurs with or up to 6 months after the chancre heals. Think flu symptoms of malaise, headache, low grade fever, and generalized lymphadenopathy. In addition, there is a localized skin rash with lesions on the palms and soles, mucous patches in the oral cavity or genital tract, condylomata lata, and patchy hair loss. This can last for weeks or months and relapses occur in about one quarter of untreated patients.

Latent syphilis is the period between resolution of secondary symptoms and onset of tertiary syphilis. Clinical symptoms are not apparent during latent syphilis but serologic tests for detection of antibodies to *T. pallidum* are positive. There are no mucosal lesions so there is no venereal transmission during this time. Two-thirds of untreated syphilis patients remain in this stage for life.

Tertiary syphilis is not common today due to curative antibiotics given to treat early syphilis or given coincidentally to treat an unrelated infection. This stage presents several years to a few decades after initial infection. It can affect any tissue or organ including nervous and cardiovascular systems. Granulomatous lesions known as gummas can appear in any tissue and cause serious complications if in the brain or heart.

Diagnosis begins with the realization that the patient's symptoms might be due to syphilis. Which test to order is best determined by contacting the lab at the facility where you are working. Dark field microscopy can identify treponemas in scrapings from primary and secondary lesions. There are serologic tests available which detect IgM and IgG antibodies. There are nontreponemal tests and specific treponemal tests.

The non-treponemal tests include RPR (rapid plasma reagin), VDRL (Venereal Disease Research Laboratory), and TRUST (toluidine red unheated serum test). These tests are rapid, inexpensive, and can monitor response to antibiotics treatment. They are positive in about 14 days after the chancre appears. 1-2% of the population will have a false positive. They can persist as positive years after treatment.

The treponemal tests are more specific and more sensitive with less false positive results. They cannot distinguish between active or past disease and cannot be used to monitor the effectiveness of treatment. These tests include the FTA-ABS (fluorescent treponemal antibody absorption assay), EIAs (various enzyme-linked immunoassays), CIAs (chemiluminescence immunoassays), and rapid point of care immunochromatographic strip assays. Traditionally nontreponemal tests have been used for screening and then confirmed with treponemal tests.

However, some facilities are using a reverse algorithm by starting with the treponemal test.

Treatment for syphilis is still 2.4 million units of benzathine penicillin G IM. This is curative for uncomplicated syphilis. Give it weekly x 3 weeks for latent, unknown duration, or tertiary syphilis. For men and non-pregnant women with early syphilis who are allergic to penicillin, the CDC recommends doxycycline 100mg bid x 14 days or tetracycline 500mg qid x 14 days, or ceftriaxone daily x 10-14 days. Azithromycin 2gms may be used, but with caution due to growing resistance.

One of the issues for the emergency department is follow up on test results to ensure proper treatment. This is already the case with chlamydia and gonorrhea testing. However, results of a positive treponema or nontreponemal test is a bit more complicated to interpret and will require more than calling in a prescription. On the other hand, not ordering the tests will ensure that the incidence of syphilis will continue to rise. Since it is a treatable disease, it would be best if we tried reducing the spread of this disease or maybe even eliminate it. It would be best to have a system set up for follow up on testing a referral to an appropriate clinic for ongoing testing and treatment as needed. This seems to be the case with much of our work in the emergency department. Having a plan makes all the difference.

Adriana's Corner

This year is just about over. The days, weeks and months just fly by. And usual chapter business must continue. I am certain 2018 will be a great year for you as emergency physicians and for the North Dakota chapter. I look forward to continuing to work with all of you the upcoming year. In the meantime, please contact [me](#) if I can help you in any way.

State Legislative Issues for 2018 by Harry J. Monroe, Jr. ACEP Director, Chapter and State Relations

Two years after the nearly miraculous successful retreat by the British army from Dunkirk, Prime Minister Winston Churchill remarked on the first actual British victory of the war by declaring, "Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning."

We may be at a similar point in our legislative battles over balance billing and out of network reimbursement. In many states, policymakers that have been considering the issue for multiple sessions will look to address the issue once and for all. Thus, it will be important that we stand ready to engage an issue that continues to pose a threat to our specialty and most importantly,

access to care for our patients. Certainly, we want to be paid fairly, but we also want to focus on making sure that insurer practices are not causing patients to delay receiving emergency care out of uncertainty as to what the insurer will pay.

ACEP has developed, and is continuing to refine, resources to help states engaging this issue. On [our website](#) you will find numerous documents that will be of help in working on this issue, including talking points, copies of written testimony produced in a number of states, information on why Medicare is not a sound benchmark for determining reimbursement, and many other materials. I would encourage you to take a look.

Additionally, we have worked hard over the last two years to build relationships with other specialty societies and the AMA, based on shared consensus principles and solutions documents that are included on the website, that have helped us collaborate on these issues. In most states that we have engaged, the national collaboration has helped with building alliances at the state level, with the result that the house of medicine has been largely united in our response to legislation. In addition to fighting off bad legislation, we have looked for opportunities to promote positive legislation on the issue, and model legislation has been developed to that end. In addition, to our collaboration with other specialties, another outside organization, Physicians for Fair Coverage, has been formed and has helped to provide and coordinate resources in this fight.

At the time of this writing, we are also working on developing regional teams of experts that can help provide assistance in terms of legislative interpretation, understanding financial impacts, and advocacy. These should be in place by the time 2018 sessions begin.

We believe that as many as 25 states will see significant efforts by legislatures to address balance billing and out of network legislation this year. If you are facing it in your state, reach out to me [via email](#) or at 972-550-0911, ext. 3204.

In addition to balance billing and out of network issues, there will be many other important issues to address in the coming year. The prudent layperson standard remains under attack in many places by both Medicaid and commercial payers. The opioid epidemic continues to be a critical public policy concern. Of course, what the federal government does about health care, and how that filters down to the state level, promises to require our attention. This will be a busy year at the state house!



ACEP - You make 50 look good!

As we wind down 2017, we kick off a year-long celebration of ACEP's 50th anniversary starting January 2018. Plan to participate in social media campaigns that highlight the highs, lows and life-changing moments in EM. Get hyped for a historical timeline following the history of our specialty as well as anniversary-themed podcasts. Watch for anniversary editions of ACEP Now and Medicine's Frontline in addition to proclamations from members of Congress and sister medical societies. Don't forget to order copy of our commemorative coffee table book featuring the breath-taking photographs that capture a day in the life of emergency physicians collected by famed photographer Eugene Richards. [Book tickets now to ACEP18](#) and our blow-out anniversary celebration in San Diego featuring an interactive history museum showcasing the journey of emergency medicine from battlefield to inner city to rural America to every spot in between.

As we enter 2018, we begin the celebration of 50 years of life saving and boundary pushing. Are you on call for 50 more?

Show Your Commitment to High Standards for Clinical Ultrasound

You have the highest standards when it comes to your clinical ultrasound program. Show that commitment to your patients, your hospital, and your payers with ACEP's Clinical Ultrasound Accreditation Program (CUAP). ACEP's [CUAP](#) is the only accreditation program specifically for the bedside, clinician-performed and interpreted ultrasound. Now also available - accreditation for non-ED clinical settings, including freestanding EDs, urgent care centers and clinics. [Apply Today!](#)

- Ensure safety and efficacy of patient care
- Meet ACEP's high standards for point-of-care delivery
- Use your own policies or draw from expert-reviewed sample documents

Geriatric Emergency Department Accreditation Program

ACEP is gearing up to accredit geriatric emergency departments. The [Geriatric Emergency Department Accreditation Program](#) will be accepting applications after the first of the year. There will be 3 levels of accreditation ranging from a minimal commitment to better elder care to a comprehensive well-rounded robust program. Accreditation shows your patients, your institution and your payers that your ED is ready to provide care to seniors and is a quality program that meets the high standards of the American College of Emergency Physicians. [Find out more.](#)

Articles of Interest in *Annals of Emergency Medicine* by Sandy Schneider, MD, FACEP ACEP Associate Executive Director, Practice, Policy and Academic Affairs

ACEP would like to provide you with very brief synopses of the latest articles in *Annals of Emergency Medicine*. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population. [Read More](#)

Policy Statements and PREPs Approved by the ACEP Board

The following policy statements and PREPs were approved by the ACEP Board of Directors at their October 2017 meeting.

Policy Statements

[Medical Transport Advertising, Marketing, and Brokering](#) - revised

[Clinical Emergency Data Registry Quality Measures](#) - new

[Mechanical Ventilation](#) - new

[Hospital Disaster Physician Privileging](#) - revised

[Unsolicited Medical Personnel Volunteering at Disaster Scenes](#) - revised

[Sub-dissociative Dose Ketamine for Analgesia](#) - new

Writing Admission and Transition Orders - revised

[The Clinical Practice of Emergency Medical Services Medicine](#) - new

[The Role of the Physician Medical Director in EMS Leadership](#) - new

[State Medical Board Peer Review](#) - new

Pediatric Medication Safety in the Emergency Department - new

[Distracted and Impaired Driving](#) - revised

PREPs

Sub-dissociative Dose Ketamine - new

Writing Admission and Transition Orders - new

Welcome New Member

Mr. Daniel M. Kolm - Grand Forks

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