Queensland Health

Congenital Anomaly Matters

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Syphilis Screening in Pregnancy: Gaps in care affecting mothers and newborns

Key Issues

Review of congenital syphilis cases has identified systemic failures in adherence to antenatal syphilis screening guidelines. This has resulted in missed opportunities for early detection and treatment. Universal screening is recommended at 10-, 28- and 36-weeks' gestation, with additional or opportunistic testing recommended for women with risk factors and clinical presentations outside of standard antenatal care.

Case Presentation*

Ann, a 25-year-old G4P3 woman, was diagnosed with syphilis during routine antenatal screening by her GP at confirmation of her pregnancy at K7. A review of her antenatal history revealed that her last recorded syphilis test was at K10 of her previous pregnancy (baby now 9 months old), which was negative.

Despite having multiple risk factors, including a complex psychosocial history, and having attended several healthcare presentations throughout that pregnancy, Ann did not receive the recommended minimum three syphilis screening tests. The tests were either missed or incorrectly documented. Further to this, syphilis screening of Ann, her baby and the placenta (PCR testing and histology) were not undertaken at birth.

It is unknown when Ann contracted syphilis. Given the time between negative to positive testing, it is possible that she acquired the infection during her third pregnancy. Her 9-month-old child is at a risk of having contracted congenital syphilis. This has the potential for significant, lifelong health consequences as well as lost opportunities for timely interventions.

Maternal risk factors for syphilis infection

Substance use: Increases exposure risk and reduces engagement with timely testing and treatment

Domestic and family violence: Limits safe access to care and opportunities for diagnosis and follow-up

Unstable housing: Disrupts continuity of antenatal care, screening, and treatment completion

Mental health and social complexity: Contributes to disengagement and delayed diagnosis in pregnancy

Late or inconsistent antenatal care: Leads to missed screening and delayed identification of infection

Untreated partners / reinfection risk: Ongoing exposure results in infection or re-infection during pregnancy

Key findings

This case highlights missed opportunities for recommended antenatal syphilis testing, with associated gaps in documentation where testing was declined. Contributing factors included poor integration between GP and hospital records, missed opportunities for catch-up testing, and failures to escalate care. These issues underscore the need for robust systems to ensure timely testing, appropriate documentation, and coordinated maternal and neonatal assessment and follow-up.

*Scenario based on a fictional clinical incident to maintain confidentiality.

Lessons Learnt

Systemic Non-Compliance with Guidelines: Antenatal syphilis screening guidelines were not consistently followed.

Missed Opportunities for Early Detection

Multiple healthcare visits were not utilised for repeat testing, despite known risk factors.

High-Risk Profile Ignored

Woman with complex psychosocial factors should have triggered heightened attention and repeat screening.

Poor Documentation and Record Integration

Incomplete or inaccurate records and lack of GP-hospital integration caused care gaps.

Post-Birth Screening Neglected

Neither mother, baby, nor placenta were tested at birth, affecting diagnosis and timely intervention and treatment.

Preventable Harm

Congenital syphilis is entirely preventable through timely screening and treatment.

Syphilis screening at key milestones in pregnancy and at birth

1. Universal syphilis screening before 10 weeks gestation (at confirmation of pregnancy or initial antenatal visit)
2. Routine rescreening at 26–28 weeks gestation
3. Routine rescreening at 36 weeks gestation OR at birth (which ever precedes)
4. If not tested at 36 weeks or a preterm birth more than 4 weeks after the last test, test the mother at birth
5. Submit the placenta for syphilis PCR and histopathology when a woman presents for birth with no or limited antenatal care or has received syphilis treatment during pregnancy, ensuring relevant history (e.g. no antenatal care or uncertain/positive syphilis status) is included on the request.
6. At birth, if the mother has no antenatal care, late or insufficient treatment or reactive serology, the infant must be examined, have serology performed, and be investigated/treated for congenital syphilis in consultation with a specialist.

References

Queensland Clinical Guideline: Syphilis and Pregnancy (Queensland Health)

Support for navigating through syphilis | Brisbane South PHN