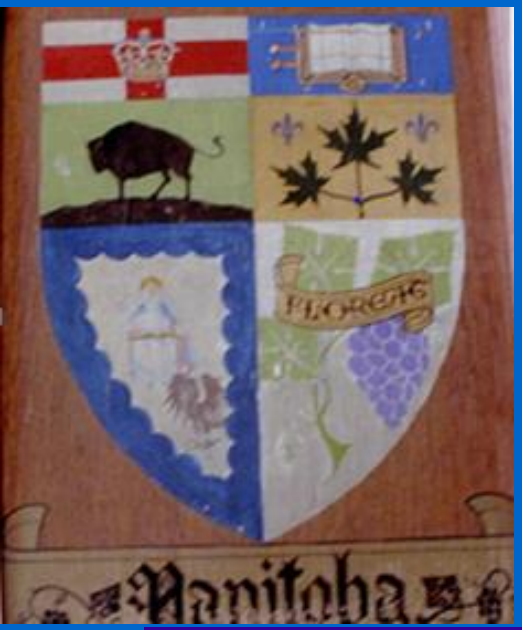
Prof. Kelly MacDonald
&
Dr. Kamran Kadhoka



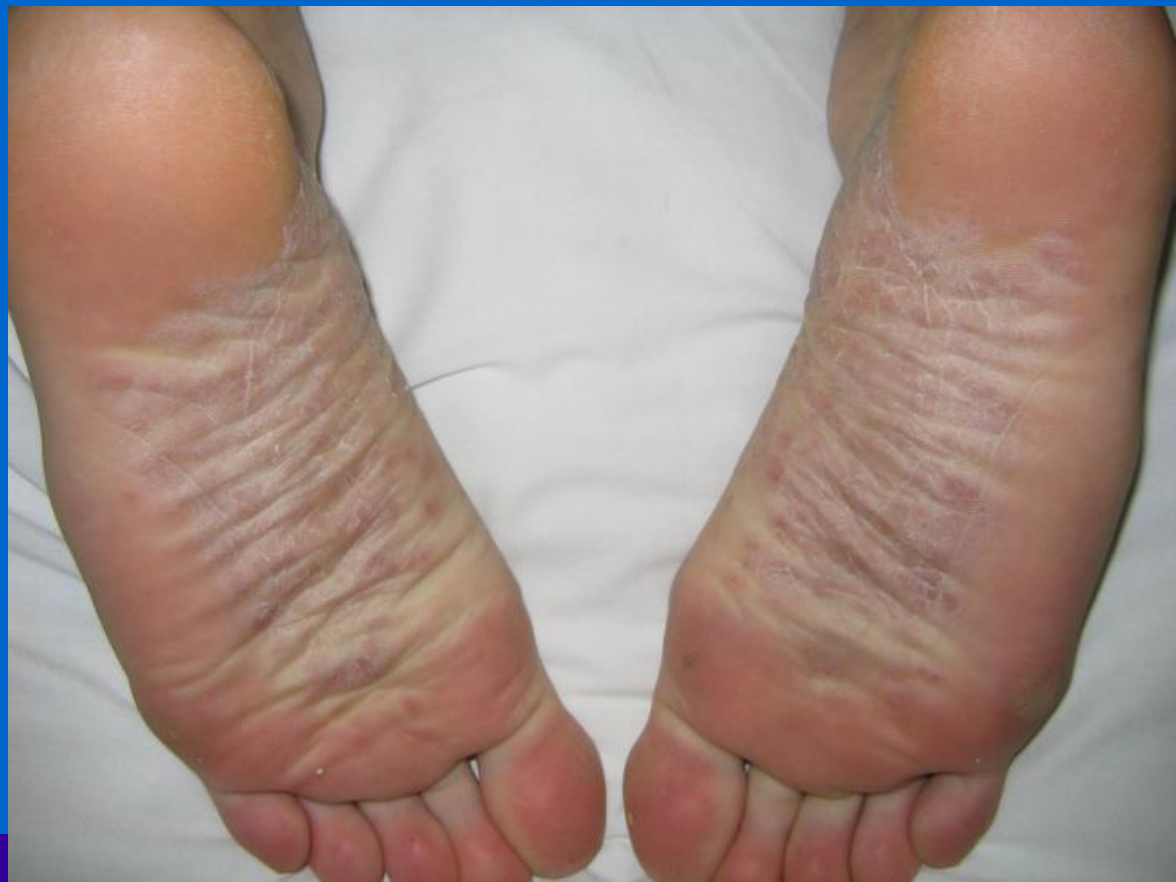
Depts. of Medicine, (Infectious Diseases) and Medical Microbiology

University of Manitoba,

Cadham Provincial Laboratory

Case

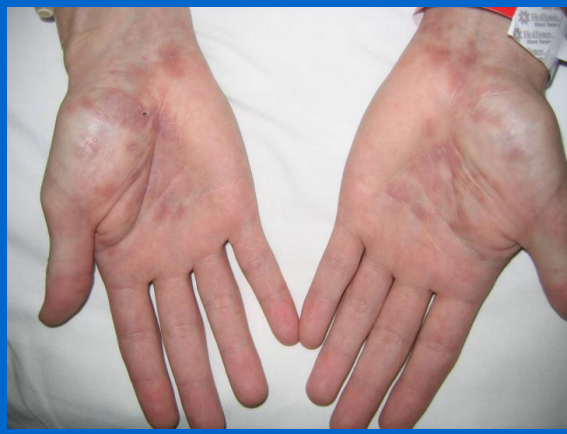
- 37-year-old male mechanic, who lives in downtown Winnipeg, presents with rash of 5 days duration

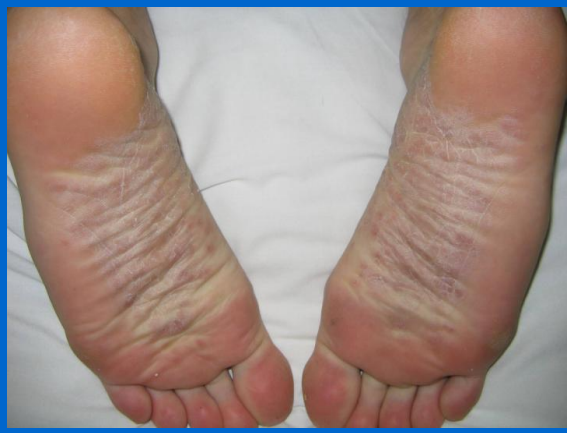


Case

What is the diagnosis?

A. Eczema
B. Erythema multiforme
C. Psoriasis
D. Seborrheic dermatitis
E. Tinea corporis (ringworm)

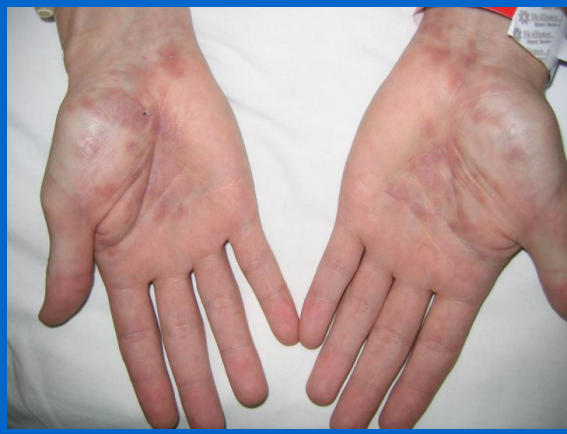


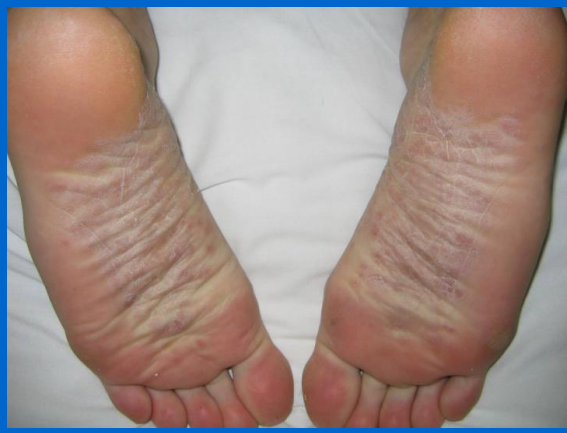


Case

What is the diagnosis?

A. Eczema
B. Erythema multiforme
C. Psoriasis
D. Seborrheic dermatitis
E. Tinea corporis (ringworm)
F. None of the above





What other history?

- no travel history
- no pets/animal contacts
- meets men on the internet and has occasional casual sexual encounters (only knows the internet IDs of 9 contacts in the last 3 months)
- also complaining of hair loss

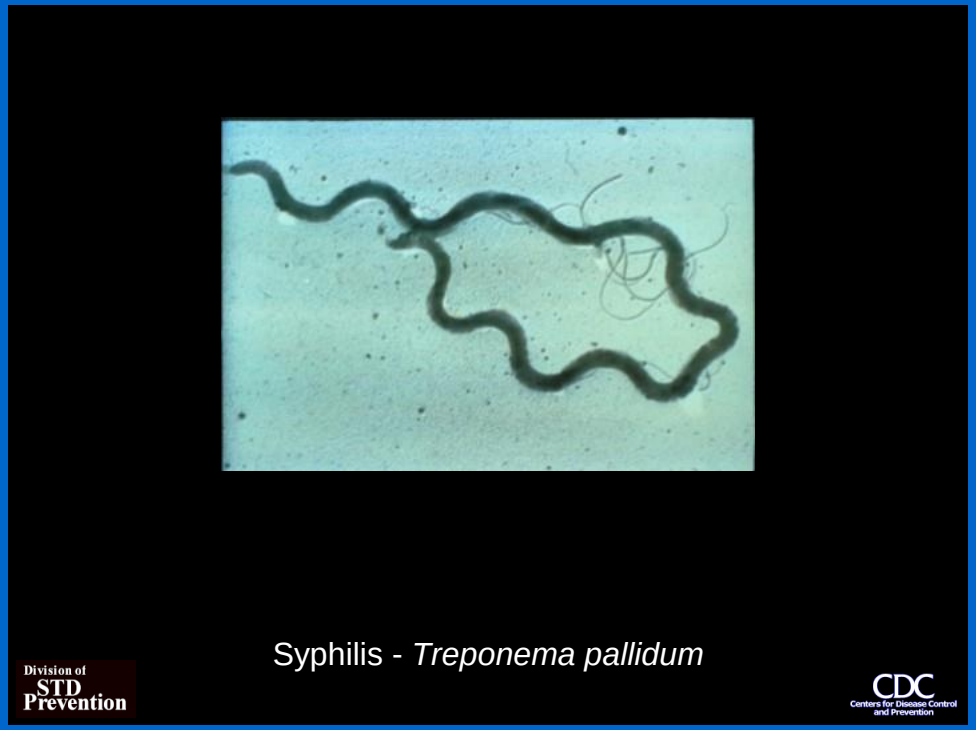
Case

What is his diagnosis UPO?

A. Primary Syphilis
B. Secondary Syphilis
C. Tertiary Syphilis
D. Latent Syphilis
E. Neurosyphilis

Syphilis – the Basics

- **Re-emerging disease (since 2000)**
- ***Treponema pallidum*, spp. *pallidum***



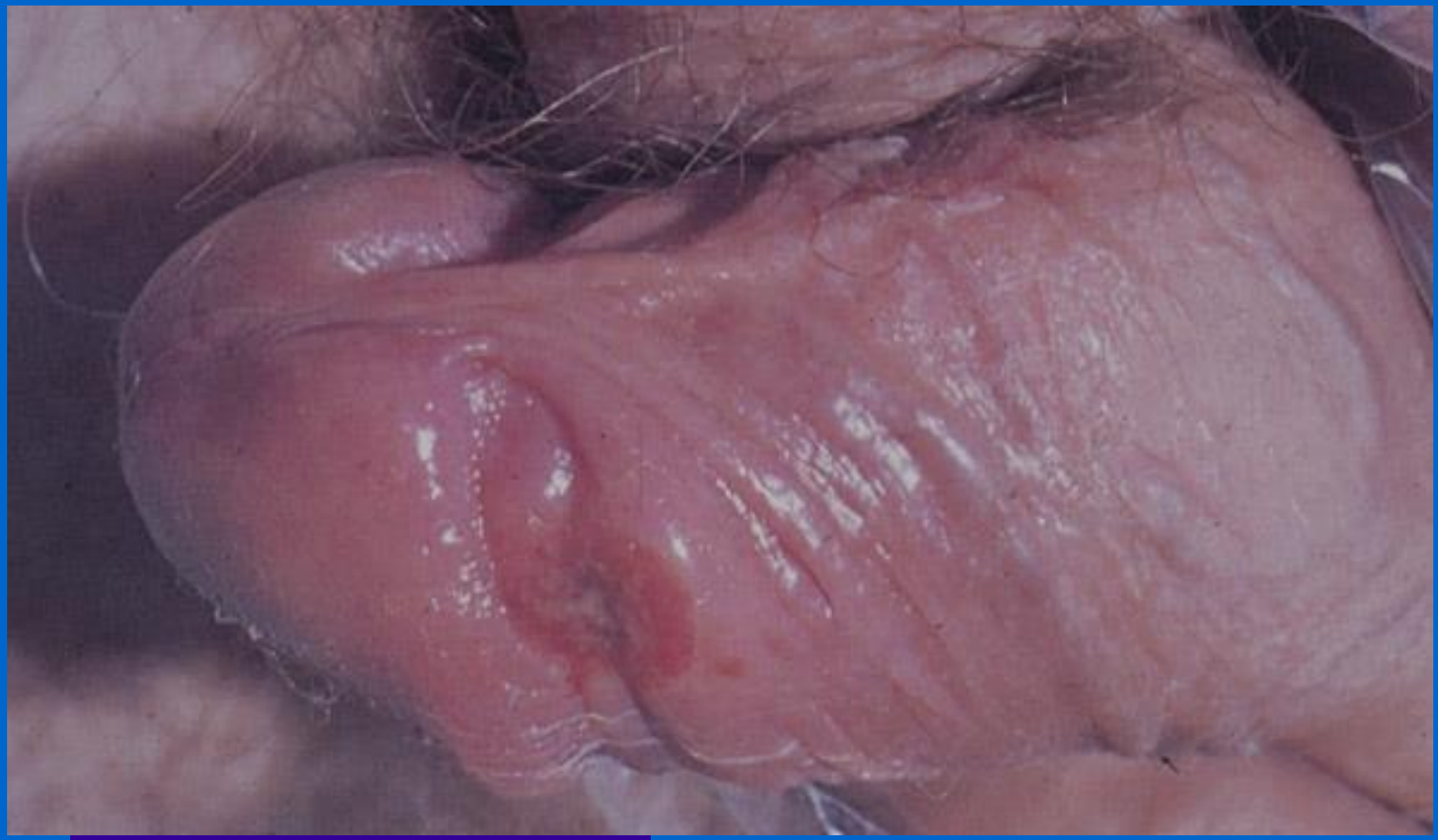
Syphilis – the Basics

- Direct (sexual) contact; blood transfusion; congenital
- Incubation Period: 10-90 days
- Stages – primary, secondary, early latent, late latent, and tertiary

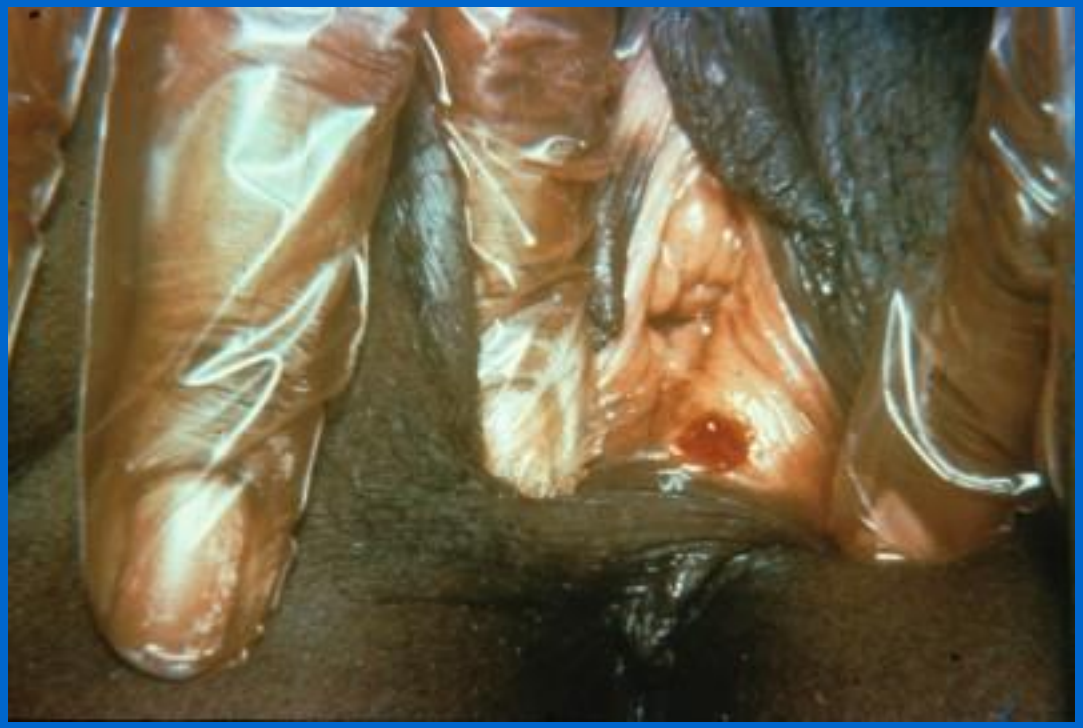
Infectious Syphilis

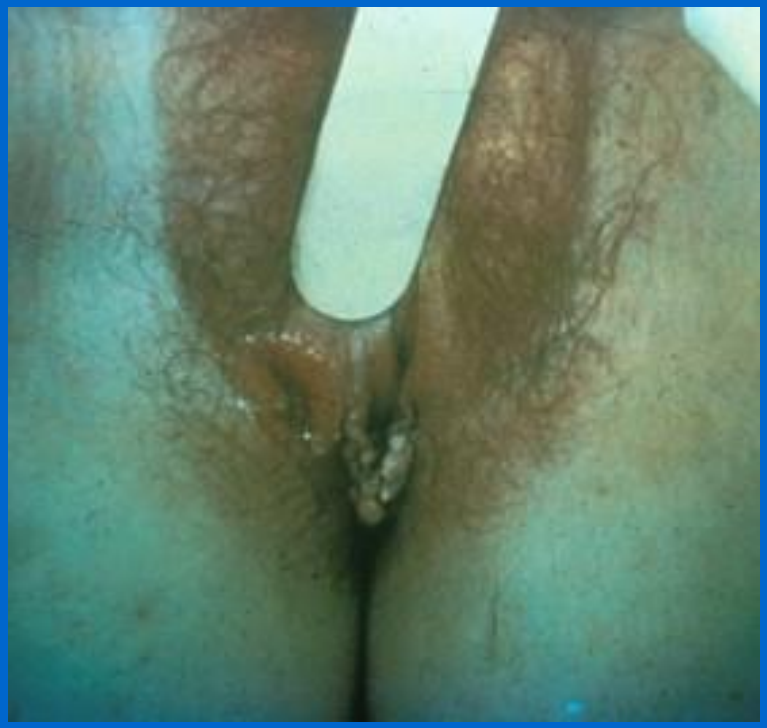
- Primary – Ulcers (chancres) on penis/vagina
- Secondary – Rash (any kind except vesicular); may be on palms of hands or soles of feet; systemic illness
- Latent – Asymptomatic (12 months)

Primary Syphilis

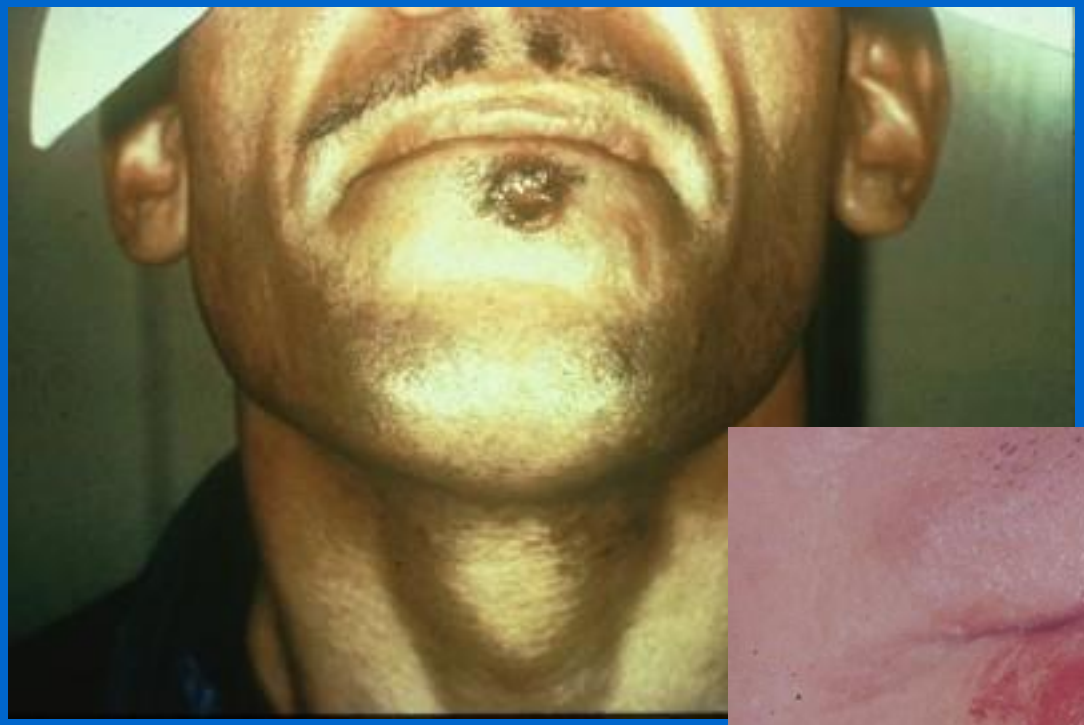


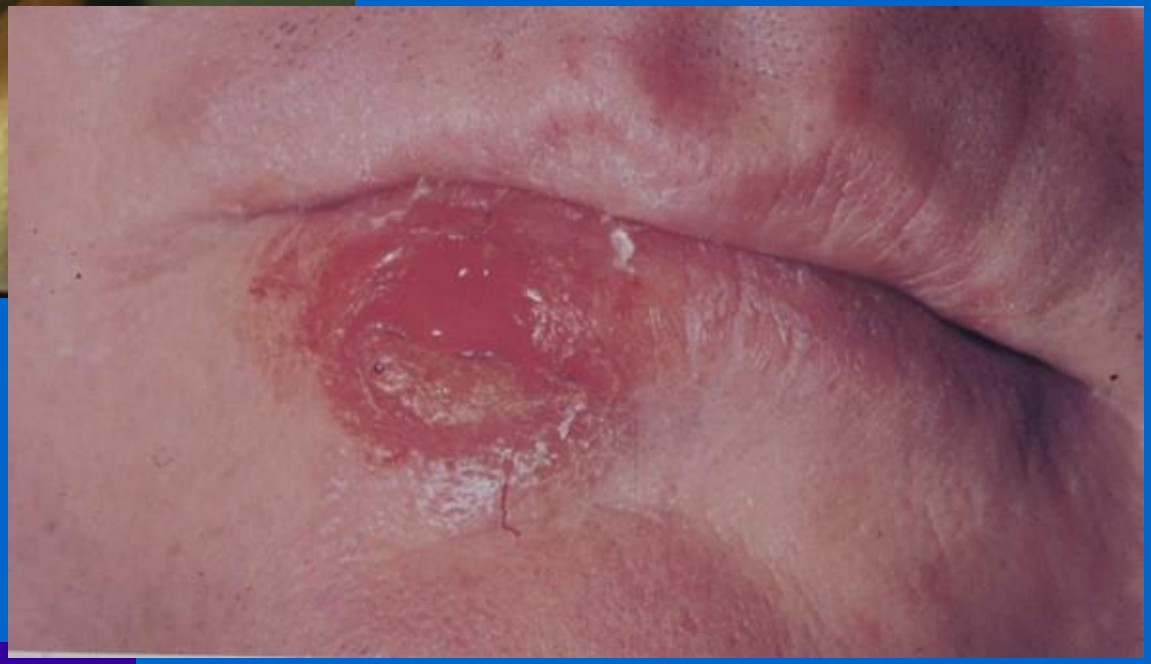
Primary Syphilis



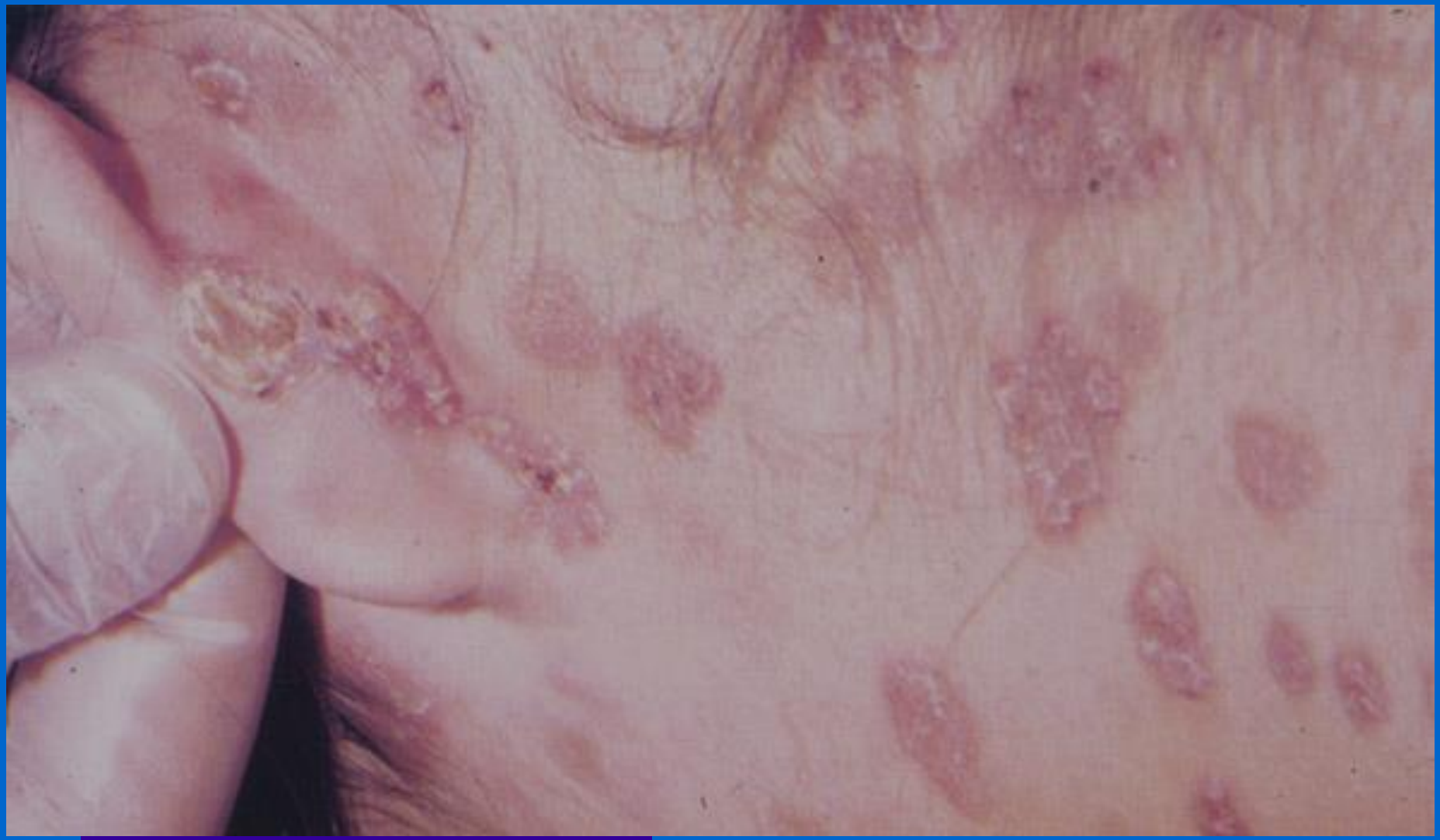


Primary Syphilis (Extragenital)

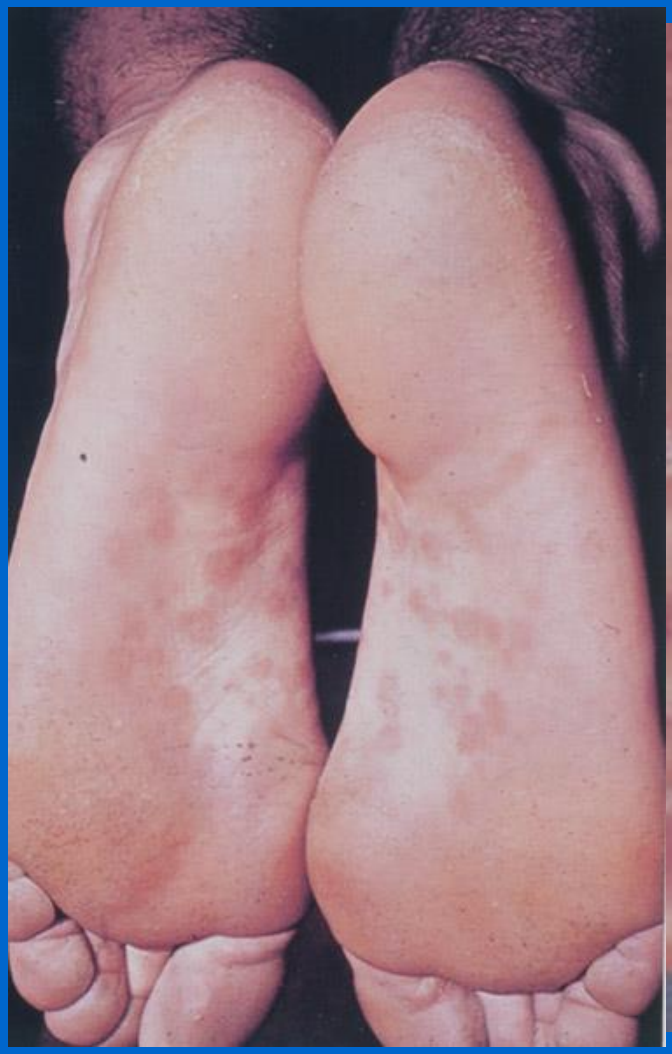


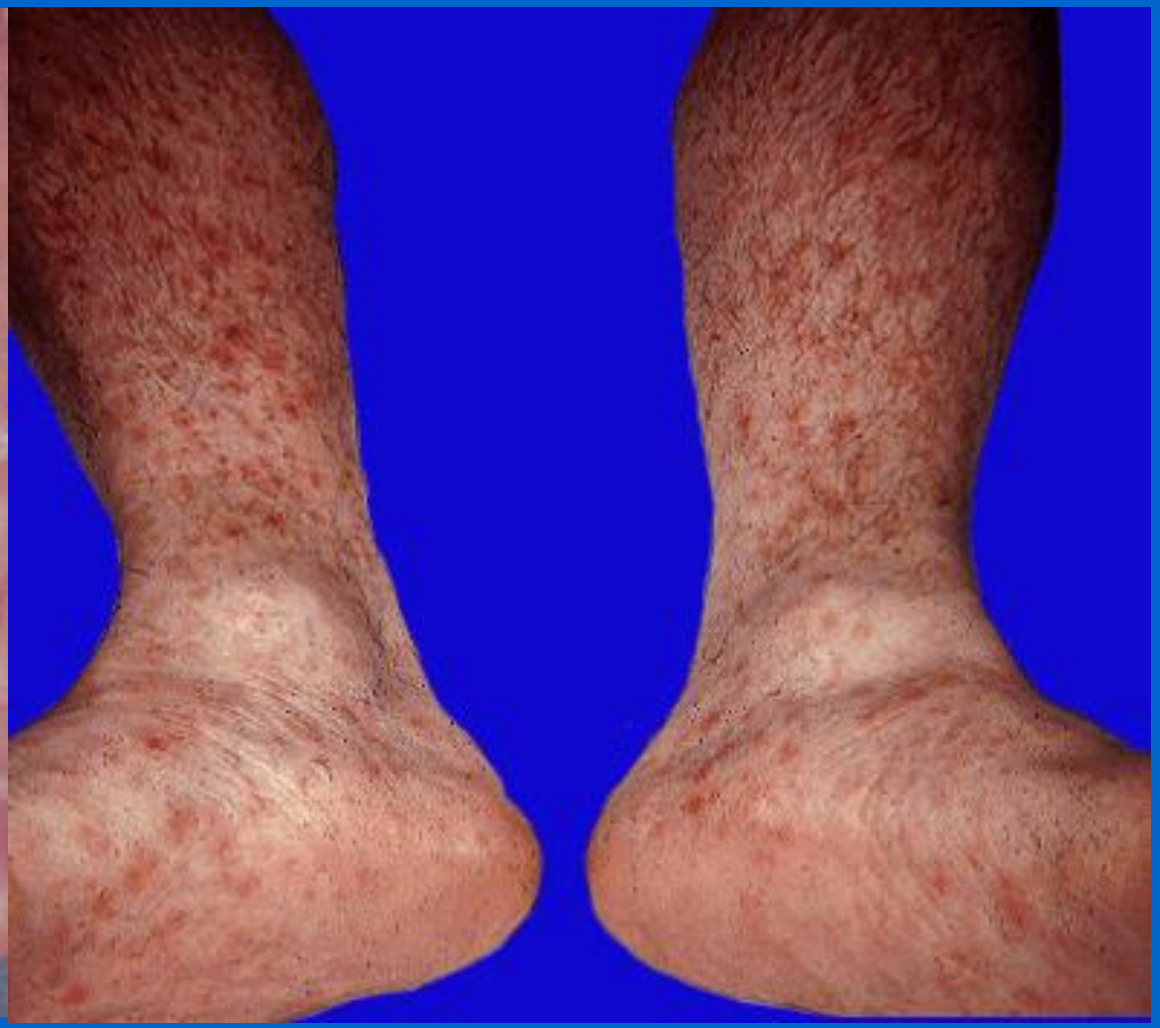


Secondary Syphilis

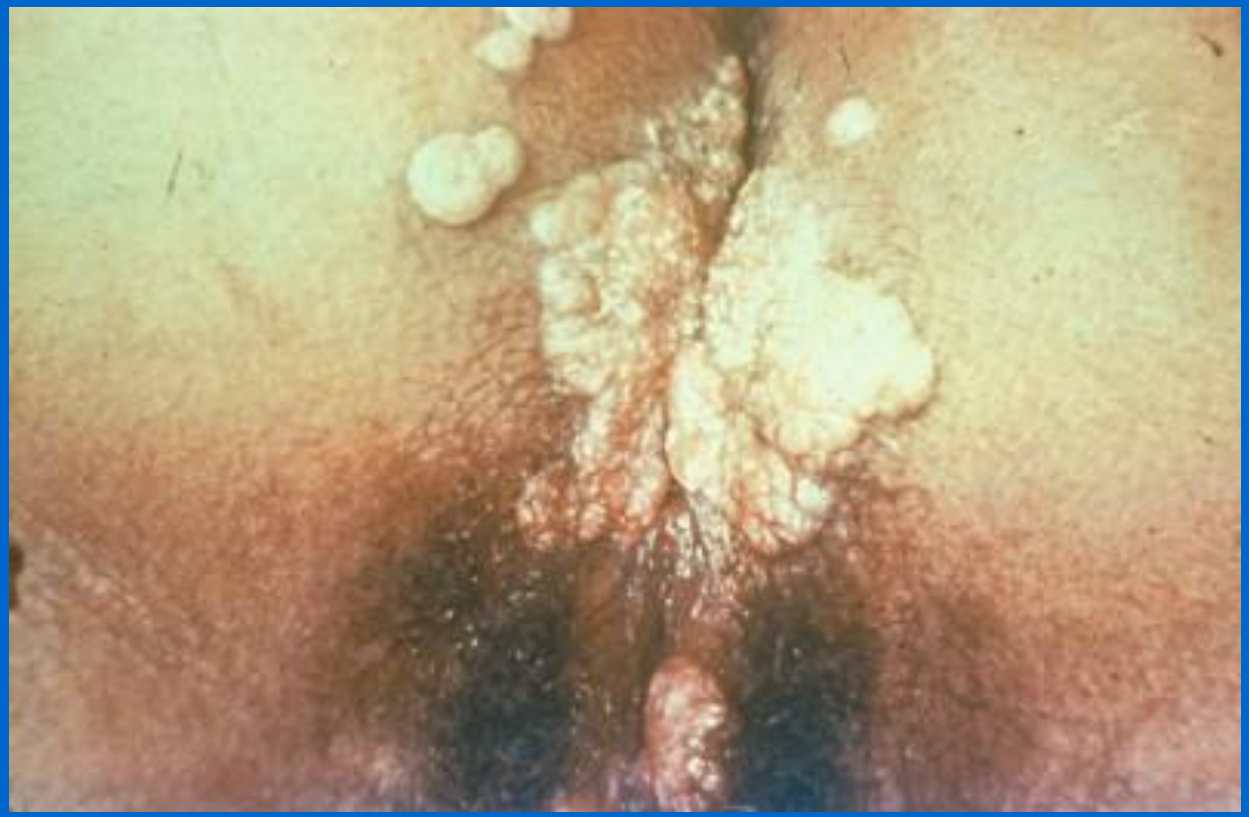


Secondary Syphilis (Palms and Soles)

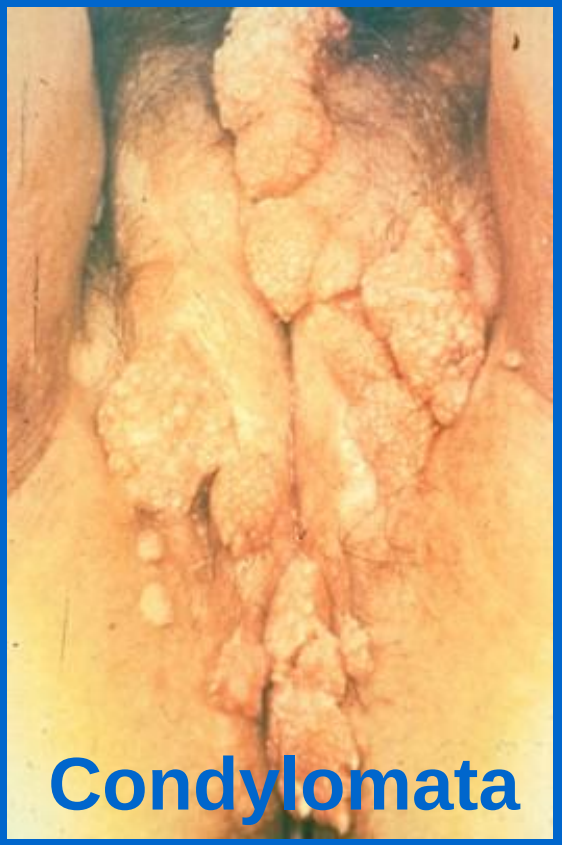




Secondary Syphilis (Condylomata)



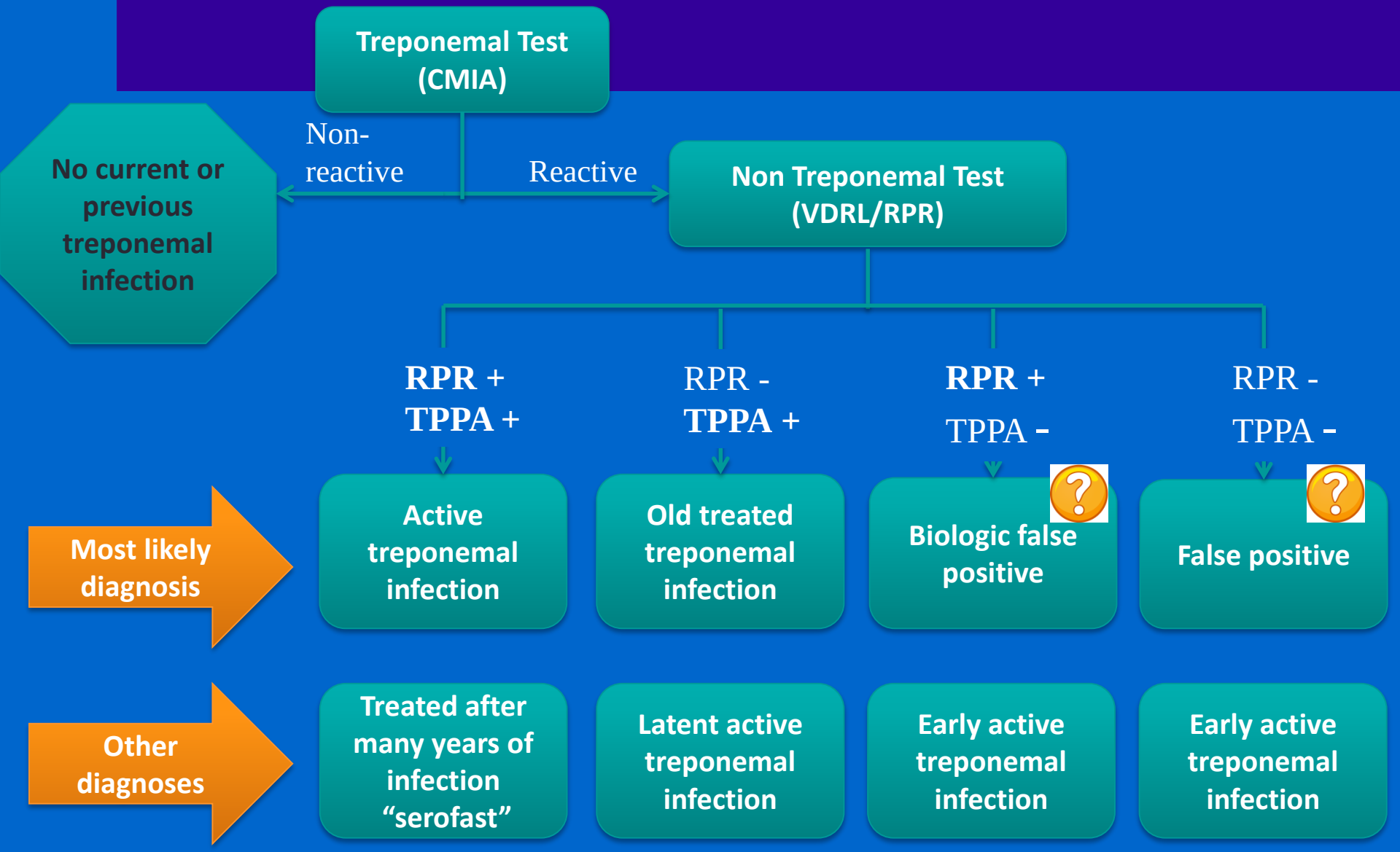
Condylomata lata



acuminata

(HPV)

Serology – Testing Algorithm



Can J Infect Dis Med Microbiol 2015;26 (Supp A)

Ordering serology

Cadham Provincial Laboratory
General Requisition

Manitoba Health

ONLY ONE SPECIMEN TYPE PER REQUISITION

All areas of the requisition must be completed (please **print** clearly)
See back for requisition/specimen instructions

Cadham Provincial Laboratory
P.O. Box 8450
750 William Avenue
Winnipeg, MB R3C 3Y1

Tel: (204) 945-6123
Fax: (204) 786-4770
E-mail: cadham@gov.mb.ca
Website: www.gov.mb.ca/health/publichealth/cpl

SEROLOGY

Serology Test Panels (see #1 over)

- ☐ STI Panel
- ☐ Post Exposure: Source Panel (1, 3)
- ☐ Post Exposure: Exposed Panel (1)
- ☐ Prenatal Panel
- ☐ Prenatal HIV OPT OUT (2)
- ☐ Blood-borne Pathogen

HIV (4) ☐ HIV1/2Ab ☐ Syphilis Screen

Hepatitis

- ☐ HAV IgG (Immunity)
- ☐ HAV IgM (acute HAV)
- ☐ HBcAb (Total)
- ☐ HBsAb (Immunity)
- ☐ HBsAg
- ☐ HCV Ab

Nucleic Acid (Plasma Only) (5)

- ☐ HBV PCR/Quant
- ☐ HCV PCR/Qual
- ☐ HCV PCR/Quant
- ☐ HCV Genotyping
- ☐ WNV PCR

Miscellaneous Serology

	Acute	Immune Status		Acute	Immune Status
CMV	☐ IgM	☐ IgG	Parvo B19	☐ IgM	☐ IgG
EBV	☐ IgM	☐ IgG	Rubella	☐ IgM	☐ IgG
HSV	☐ IgM	☐ IgG	Toxoplasma	☐ IgM	☐ IgG
Measles	☐ IgM	☐ IgG	Varicella	☐ IgM	☐ IgG
Mumps	☐ IgM	☐ IgG	WNV	☐ IgM	

☐ Lyme Ab ☐ H. pylori Ab ☐ Mycoplasma pneumoniae IgM

Syphilis: How to treat?

	First	Second	Allergy
SYPHILIS (Primary, Secondary, Early latent)	Benz Pen G 2.4 M units IM X1 (?Azithro 2g)	Ceftriaxone 1g IM daily x10 d	Doxycycline 100mg PO BID x14 d
SYPHILIS (Late latent)	Benz Pen G 2.4 M units IM wkly X3	Ceftriaxone 1g IM daily x10 d	Doxycycline 100mg PO BID x28 d
Neurosyphilis	Cryst Pen G 3-4 M units IV q4h X10-14 d	Proc Pen G 2.4 M units IM daily X10-14 d (+ probenecid) or Ceftriaxone 2g IM/IV daily x10-14 days	

How to obtain Bicillin®?

- Benzathine penicillin G (Bicillin®) 2.4 million units IM in a single session (separated into 2 injections)
- Bicillin® in preloaded syringes provided free of charge by Manitoba Health
- Can only be obtained by faxing a completed Manitoba Health STD Medication Administration Form (call Materials Distribution Agency at 945-0570 or download form:

http://www.gov.mb.ca/health/publichealth/cdc/protocol/form11.pdf

Manitoba Health STI Medication Order Form (PLEASE PRINT)

Manitoba

Fax order to: Taché Pharmacy – Fax: (204) 231-1739 • Phone: (204) 233-3469 • For Inquiries only e-mail tache@mts.net

Date (yyyy/mm/dd)	_____/_____/_____	Contact Person:	
Facility Name:		Physician:	
Address:			
Telephone #:		Ext:	

Refer to Sexually Transmitted and Blood-Borne Infections webpage http://www.gov.mb.ca/health/publichealth/cdc/sti/index.html

All treatments provided to patients must be recorded and reported to Manitoba Health using the STI Administration Form (http://www.gov.mb.ca/health/publichealth/cdc/protocol/stiadminform.pdf)

Units Ordered	Drug	Dosage Forms & Unit Quantity	Indication
CHANCROID			
	Ceftriaxone	250 mg x 1 vial	First line treatment for adults and adolescents
	Erythromycin base	250 mg x 56 tablets	Alternative treatment for cephalosporin or penicillin allergy.
	Azithromycin	250mg x 4 tablets	
CHLAMYDIA*			
	Azithromycin	250 mg x 4 tablets	First line treatment in children > 9 years of age and adults
	Doxycycline	100 mg x 14 capsules	Alternative treatment in children > 9 years of age and adults
	Erythromycin base	250 mg x 56 tablets	Pregnant and lactating women
	Amoxicillin	500 mg x 21 capsules	Pregnant and lactating women allergic to erythromycin or azithromycin
GONORRHEA*			
	Cefixime	400 mg x 2 tablet	First line treatment in combination with 1 g azithromycin
	Ceftriaxone	250 mg x 1 vial	First line treatment in combination with 1 g azithromycin
	Azithromycin	250 mg x 4 tablets	First line treatment treatment in combination with cefixime OR ceftriaxone
	Azithromycin	250 mg x 8 tablets	Alternative treatment when there is severe cephalosporin allergy
LGV			
	Doxycycline	100 mg x 42 capsules	First line treatment
	Erythromycin base	250 mg x 168 tablets	Alternative treatment
	Azithromycin	250 mg x 12 tablets	Alternative treatment
PID			
	Ceftriaxone	250 mg x 1 vial	Recommended treatment for acute PID (in combination with doxycycline and metronidazole)
	Doxycycline	100 mg x 28 capsules	Recommended treatment for acute PID (in combination with ceftriaxone and metronidazole)
	Metronidazole	250 mg x 56 tablets	Recommended treatment for acute PID (in combination with doxycycline and ceftriaxone). Metronidazole is included to provide optimal anaerobic coverage.
	Azithromycin	250 mg x 7 tablets (1 tablet daily for 7 days) OR	Alternative treatment for acute PID (in combination with oral metronidazole) for patients with cephalosporin contraindication.
	Azithromycin	250 mg x 8 tablets (4 tablets once weekly for 2 weeks)	
SYPHILIS			
	Benzathine Penicillin G† (Bicillin)	1.2 MU x 2 syringes	First line for primary, secondary, and early latent stages of infection and epidemiologic treatment of sexual contacts
	Benzathine Penicillin G† (Bicillin)	1.2 MU x 6 syringes	First line for late latent infection, infection of unknown duration and tertiary syphilis NOT involving the CNS
	Doxycycline	100 mg x 28 capsules	Alternative treatment for penicillin allergic adults and adolescents staged with primary, secondary or early latent infection
	Doxycycline	100 mg x 56 capsules	Alternative treatment for penicillin allergic adults and adolescents staged with late latent infection, infection of unknown duration or tertiary syphilis NOT involving the CNS
	Azithromycin	250 mg x 8 tablets	Azithromycin alone should not be routinely used as a treatment option for early or incubating syphilis as azithromycin resistance has been reported and is increasing*

*Pediatric dosing available upon request.
*In exceptional circumstances, azithromycin should be reserved for suspect syphilis cases (at the time that serology is performed) only if Bicillin (Benzathine Penicillin G) is not readily available, with the understanding that the patient will require Bicillin if their serology confirms that they have syphilis.
†Must be stored in a refrigerator that is temperature monitored and kept between 2-8°C.

Printed Name		Physician's Signature:	

http://www.gov.mb.ca/health/publichealth/cdc/protocol/form11.pdf

SYPHILIS			
	Benzathine Penicillin G† (Bicillin)	1.2 MU x 2 syringes	First line for primary, secondary, and early latent stages of infection and epidemiologic treatment of sexual contacts
	Benzathine Penicillin G† (Bicillin)	1.2 MU x 6 syringes	First line for late latent infection, infection of unknown duration and tertiary syphilis NOT involving the CNS
	Doxycycline	100 mg x 28 capsules	Alternative treatment for penicillin allergic adults and adolescents staged with primary, secondary or early latent infection
	Doxycycline	100 mg x 56 capsules	Alternative treatment for penicillin allergic adults and adolescents staged with late latent infection, infection of unknown duration or tertiary syphilis NOT involving the CNS
	Azithromycin	250 mg x 8 tablets	Azithromycin alone should not be routinely used as a treatment option for early or incubating syphilis as azithromycin resistance has been reported and is increasing*

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†Must be stored in a refrigerator that is temperature monitored and kept between 2-8°C.

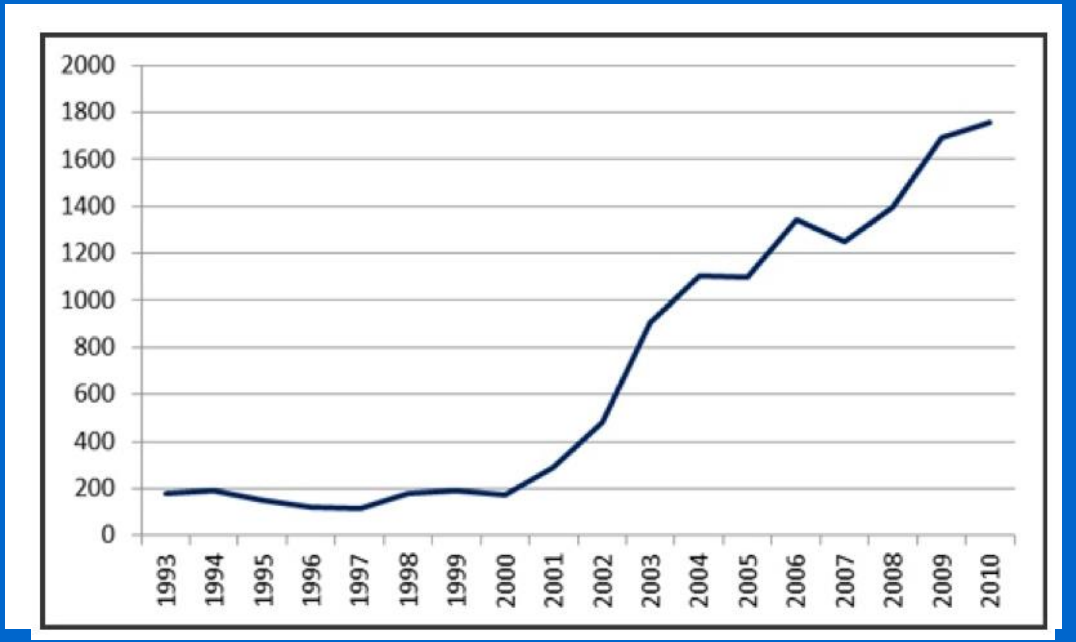
Printed Name		**Physician's Signature:**	

September 2015

Background - Canada

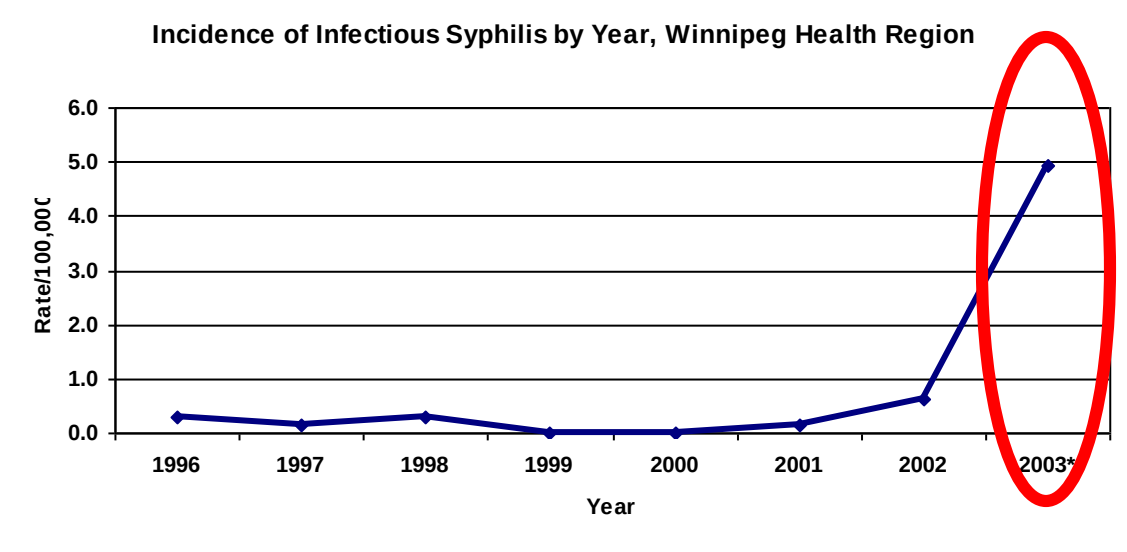
- Since 2000, there have been outbreaks of infectious syphilis reported in Vancouver, Calgary, Edmonton, Toronto, Ottawa, Montreal, Halifax …

- Vancouver - MSM
- Calgary - MSM/Hetero
- Edmonton – MSM/Hetero
- Toronto - MSM
- Ottawa - MSM
- Montreal - MSM
- Halifax - MSM



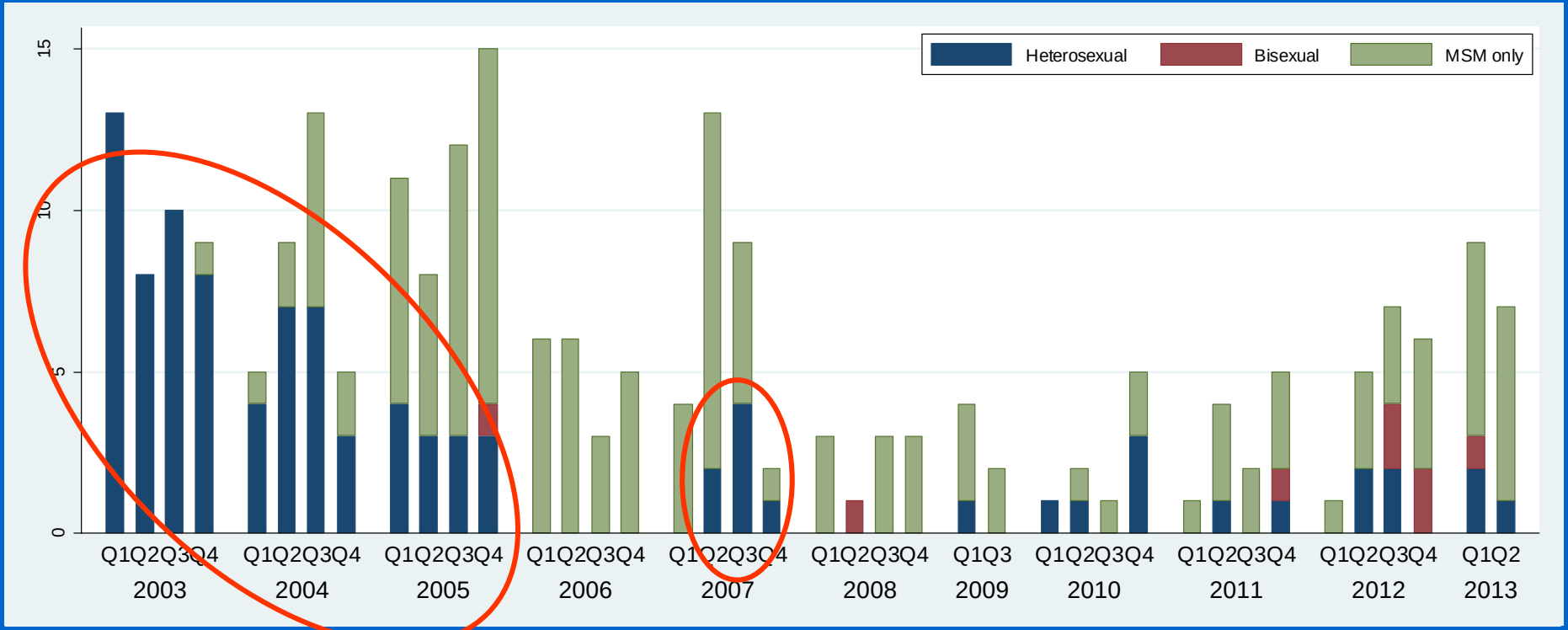
Background - Winnipeg

- Until January 2003, the incidence of syphilis infection (imported cases) had remained stable at less than 1 case per 100,000 population
- No *locally acquired* infectious syphilis since 1995



Infectious Syphilis Cases - WHR

N=238



Source: Syphilis Surveillance Database, Population and Public Health Program, Winnipeg Regional Health Authority, June 2013

Outbreak Demographics

Predominant risk factors

- 2007 cluster
  - place of meeting at inner city bars
  - significant alcohol use
  - casual unprotected sex (male-female)
  - no link to sex trade work
  - numerous sexual networks ranging in size from 2 to more than 15 individuals

Outbreak Demographics

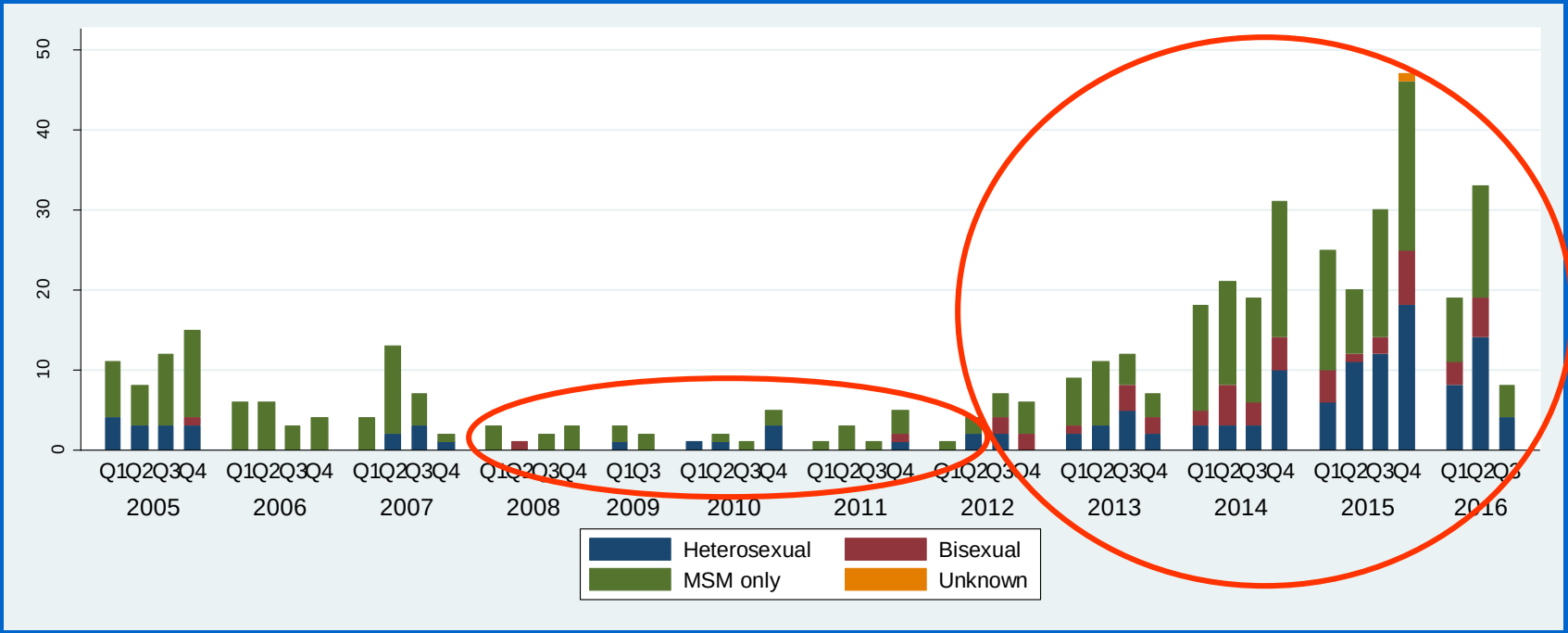
Predominant risk factors

- December 2003 to January 2009
  - exclusively MSM
  - frequenting MSM-specific meeting places
  - anonymous unprotected sex (male-male)

- **40-50% HIV +**

Infectious Syphilis Cases – WHR*

N=456



Source: Syphilis Surveillance Database, Population and Public Health Program, Winnipeg Regional Health Authority, October 2016

*Has postal code in WHR or is identified as resident in WHR; excludes cases not resident in Winnipeg

Demographics (WHR* cases 2012-16)

- >320 Infectious Cases (since 2012 Q3)
- 83% male (63% MSM + 16% bisexual)
- Downtown (30%), Point Douglas (13%), and River Heights (9%)
- 83% “locally acquired” (10% “imported”)

*Has postal code in WHR or is identified as WHR resident

Demographics (WHR* cases 2012-16)

- 42% “meeting” on social media
- 19% HIV (?resistant) – although much lower recently – 7% in 2016
- 71% primary/secondary
- 76% 20-49 yo

*Has postal code in WHR or is identified as WHR resident

Infectious Syphilis – Rural Mb

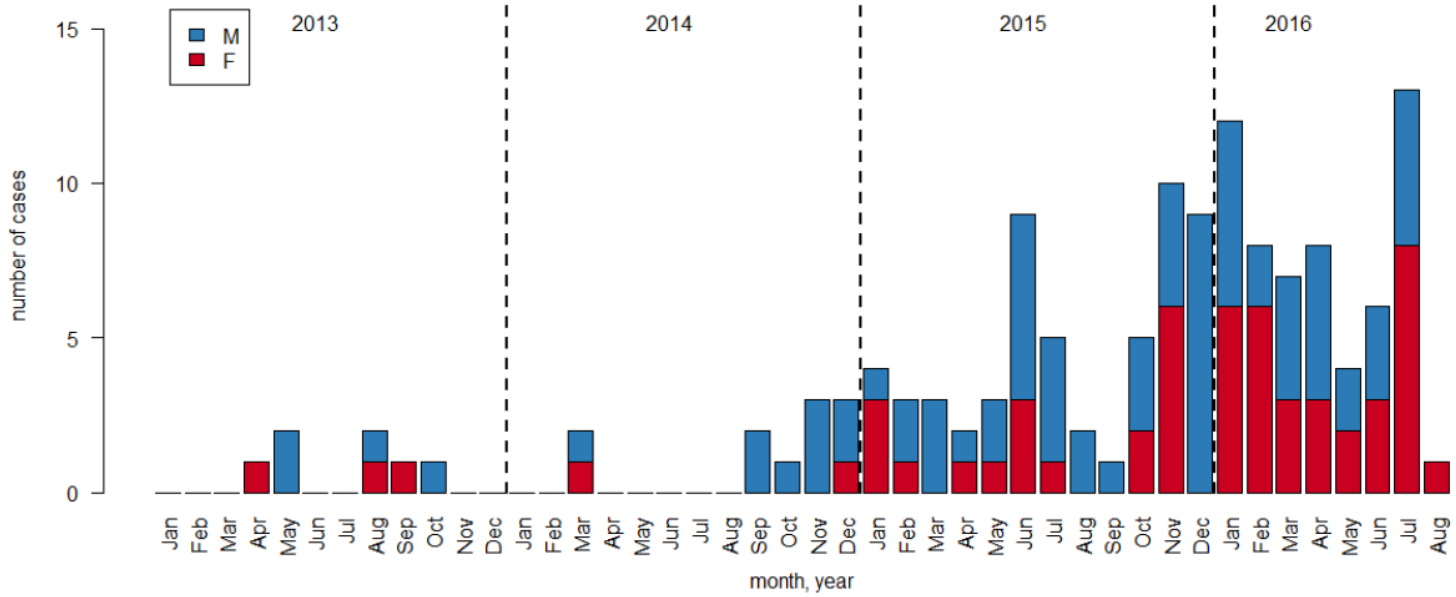


Figure 5: Distribution of infectious syphilis per month and by sex at the Northern RHA 01 Jan 2013 to 29 Aug 2016.

Outbreak summary

Predominant risk factors

- September 2012 to October 2016
  - mostly MSM/MSMW
  - meeting online or via mobile phone apps
  - anonymous unprotected sex (male-male)
  - increasing heterosexual transmission (?bisexual bridges, sex trade)

- Less than 10% are HIV + (all male)

INFECTIOUS SYPHILIS MANAGEMENT TOOL

WHO SHOULD I TEST?

ALL PERSONS WHO PRESENT WITH SYMPTOMS OF SYPHILIS such as painless genital, anal or oral ulcers, generalized maculopapular rash (typically including palms and soles) and/or lymphadenopathy.

See Manitoba Health, Healthy Living and Seniors (MHHLS) protocol (below) for details on clinical presentations

IN ADDITION TO TESTING SYMPTOMATIC PERSONS, ALSO SCREEN THE FOLLOWING PERSONS:

- ALL pregnant persons - congenital syphilis is often severe, disabling, and life-threatening
- ALL persons reporting unprotected sex with casual or anonymous partners should be routinely tested for sexually transmitted infections (STI) every 3-6 months
- ALL persons requesting STI testing
- ALL persons with any confirmed or suspected STI such as gonorrhea, chlamydia or HIV
- consider offering serology for all patients as part of routine care

WHO IS INFECTIOUS?

PRIMARY SYPHILIS: painless genital, anal or oral ulcerative lesions, +/- inguinal lymphadenopathy. The initial ulcer typically heals spontaneously.

SECONDARY SYPHILIS: usually a generalized maculopapular nonpruritic rash (typically including palms and soles) +/- other rash types, +/- fever, +/- generalized lymphadenopathy +/-alopecia +/-condyloma lata.

EARLY LATENT SYPHILIS: cases are asymptomatic, only detected with serologic screening.

NOTE: *neurosyphilis can occur during any stage of infection. Consult ID if neurologic symptoms.*

HOW DO I TEST?

- 5-10 ml blood in a red-stoppered tube or a serum separator tube (red top with yellow cap)
- Cadham Provincial Laboratory (CPL) requisition form should request syphilis serology testing and HIV antibody testing; and should provide information on reason for testing, including symptoms or suspected stage of syphilis. (Consider choosing CPL's STI panel which includes serology testing for syphilis, HIV and hepatitis B and test for hepatitis C as well.)
- Swab ulcers, sores, or moist skin lesions with a dacron swab (ex: swab from GenProbe package) of the lesion and place into viral transport medium. The sample must remain refrigerated until sent to CPL and the CPL requisition should clearly indicate the site and test requested: T. pallidum PCR testing.

WHAT IS THE TREATMENT?

- Benzathine penicillin G (Bicillin®) 2 injections of 1.2 million units IM in a single session (2.4 MU total). See MHHLS protocol for information on allergy, pregnancy and HIV positive persons.
- The Bicillin® in preloaded syringes is provided free of charge by MHHLS (see order form below).
- Sex contacts of known syphilis cases MUST ALSO immediately be offered treatment for syphilis, without awaiting testing results.
- When staging is questionable in asymptomatic person, consider staging as Early Latent for reporting purposes, but treating as Late Latent (3 weekly treatments of Bicillin).
- Follow serologic response as per provincial protocol and current outbreak response. If titres do not decrease as per protocol, repeat HIV testing and consult ID.

IS IT REPORTABLE? Cases of syphilis are reportable under The Public Health Act, as are identified contacts of cases. If you are contacted by a public health nurse for follow up of your patient who has an STI, your collaboration and assistance would be greatly appreciated.

WHERE CAN I GET MORE INFO?

- Any complicated cases, all cases of neurosyphilis, or for assistance, consult Infectious Diseases.
- Consult Pediatric Infectious Diseases for any pregnant patient diagnosed with syphilis, any newborn if maternal syphilis was diagnosed at any time during pregnancy, or if congenital syphilis is suspected.
- MHHLS – Syphilis Protocol http://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf
- CPL -Cadham Provincial Laboratory – Serology section: 204-945-6123
- MHHLS STI Medication Order Form http://www.gov.mb.ca/health/publichealth/cdc/protocol/form11.pdf

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

Manitoba

POSITIVE SYPHILIS SEROLOGY

CLIENT HISTORY OR CADHAM LAB DOCUMENTATION OF REMOTE POSITIVE SYPHILIS SEROLOGY?

NO
NEW INFECTION:
REPEAT SYPHILIS SEROLOGY SAME DAY AS TREATMENT
TEST FOR GONORRHEA, CHLAMYDIA, HIV & HEPATITIS B AND C
DO A SEXUAL HEALTH HISTORY & PHYSICAL TO STAGE INFECTION

STAGING: SYMPTOMS?[1]

- **CHANCRE** — ORAL, ANAL, VAGINAL, PENILE SWAB FOR SYPHILIS PCR → **PRIMARY**
- **RASH** — ALOPECIA, LYMPHADENOPATHY → **SECONDARY**
- **NO** → **LATENT**

PRIMARY / SECONDARY:
TREAT (2.4 MU BICILLIN) x1
FOLLOW SEROLOGY AS PER PROTOCOL
COLLECT INFORMATION ABOUT CONTACTS
COMPLETE FORM FOR CONTACT TRACING

LATENT:
SYMPTOMS/ EXPOSURE IN LAST 12 MONTHS? OR 4 FOLD RISE IN VDRL/RPR TITRE?

- **YES:** EARLY LATENT → TREAT (2.4 MU BICILLIN) x1; FOLLOW SEROLOGY AS PER PROTOCOL; COLLECT INFORMATION ABOUT CONTACTS; COMPLETE FORM FOR CONTACT TRACING
- **NO:** LATE LATENT → TREAT (2.4 MU BICILLIN) WEEKLY x3; FOLLOW SEROLOGY

NEWBORNS: IF MATERNAL SYPHILIS WAS DIAGNOSED AT ANY TIME DURING PREGNANCY, OR IF CONGENITAL SYPHILIS IS SUSPECTED, CONSULT PEDIATRIC INFECTIOUS DISEASES.

YES
POSSIBLE REMOTE CASE:
COLLECT DETAILS ABOUT PREVIOUS INFECTION
DO SEXUAL HEALTH & IMMIGRATION HISTORY AND PHYSICAL
TEST FOR GONORRHEA, CHLAMYDIA, HIV & HEPATITIS B AND C

SYMPTOMS?

- **YES:** REFER TO NEW INFECTION
- **NO:** EXPOSURE TO INFECTIOUS CASE, CURRENT UNPROTECTED SEX, RISE IN VDRL/RPR, OR OTHER REASON TO SUSPECT NEW INFECTION?
  - **NO:** LIKELY AN OLD TREATED CASE
    - **HISTORY OF TREATMENT:** NO FOLLOW UP REQUIRED
    - **NO HISTORY OF TREATMENT:** STAGE AND TREAT AS LATE LATENT
  - **YES:** RETEST IN 7-21 DAYS
    - **4 FOLD RISE IN VDRL/RPR:** NEW INFECTION (REFER TO EARLY LATENT)
    - **NO CHANGE IN VDRL/RPR:** RETEST IN 2-3 MONTHS; STAGE AND TREAT AS LATE LATENT

1. NEUROSYPHILIS CAN OCCUR DURING ANY STAGE OF INFECTION. CONSULT ID IF NEUROLOGIC SYMPTOMS.

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé

Manitoba

Outbreak Interventions

- Assertive Testing Strategy (SasP)

- Bathhouse Outreach
- Case Management (TasP)
- Social media advertising
- Health Care Provider Information
- Mapping (“frequent transmitters”)
- Contact Notification (anonymity)

Assertive Testing Strategy

- Offer q3mo syph testing to all previous syphilis cases (phone/text/email reminders)
- Only 22% completed 3/6/9/12 mo testing
- 20 repeat syphilis infections detected (10% of all cases/12 mo; 2 new HIV)
- Very positive PHN/client interaction
- Future – focus on “core transmitting networks” = MSM/MSMW, <35 yo, past Hx STBBI (HIV), low income

Case One:

28 y. pregnant female with a history of spontaneous first trimester abortion x 2, and is seen at 10 weeks of pregnancy for a first screening visit. She has no complaints and is in a monogamous relationship. She has no chronic illnesses and no history of STI.

Physical Exam: normal

Lab Tests:

HBSAg – HBSAb + , HIV-

Rubella - Chlamydia, GC both negative,

Syphilis: CMIA +, TPPA+, RPR –

Case One cont'd

① What does this test result mean?

Two different Treponema specific screening tests are positive but RPR neg.

- could be very early syphilis , late-latent or treated syphilis

② What should you do next?

Repeat test in 7-10 days

③ Is treatment advised? If so what?

If persistently positive, treat as late-latent syphilis, since patient is pregnant, worst case scenario is passing syphilis to fetus, Treat with 3 doses of IM penicillin 2.4 mil. U x 3 doses

④ Is anything advised after treatment?

Document Treatment! Since RPR negative no need to follow titers.

Case Two

A 63 year old female Filipino bookkeeper returns from an ophthalmologist referral with confirmed uveitis.

PMH: hypertension, elevated lipids.

Review of systems is negative, Social History: married with adult sons. No history of TB or STI.

Physical Exam: normal, eye exam not done

Lab Tests: HBSAg – , HBSAb + , Toxo -, CMV-, HIV-

Syphilis: CMIA +, TPPA-, RPR –

Case two cont'd

① What does this test result mean?

The CMIA indicates a positive screening Treponemal test for syphilis but the TPPA, a second Treponemal test for syphilis aimed at a different antigen is negative, as is the RPR, a non-Treponemal test.

② What should you do next?

Since both a second Teponema test and non-Treponemal test are negative, we conclude the first test (CMIA) is a False Postive and *no further testing is necessary*

③ Is syphilis treatment advised? If so what? ***NO!***

④ Is contact tracing advised? No

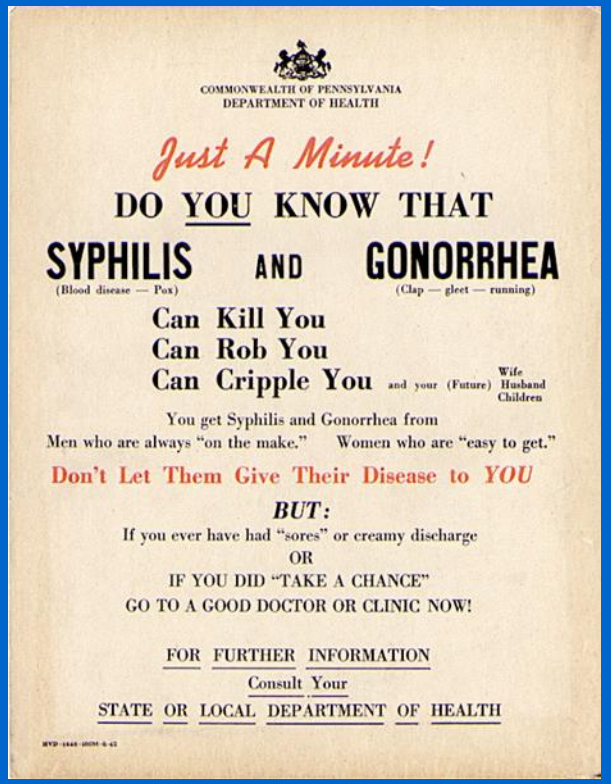
④ What about the uveitis? It still needs workup! *TB, lymphoma, spondyloarthritis etc ..*

Summary

- Syphilis outbreak in 2005-2006 was in large part heterosexual, traditional risk factors operated, traditional control measures were successful to manage it
- Recent outbreak in 2013-16 is more -social media driven , fewer imported cases, highly infectious, multifocal –all over province: rural as well as northern,
- Large infectious MSM component with bisexual men bridging the epidemic into the female population
- Traditional control methods less successful, resorting to novel methods such as assertive or intensive testing strategies in key populations have other risk factors.

Acknowledgements

Kamran Kadkhoda my colleague and expert on syphilis diagnostics in Manitoba
Allan Ronald who taught me about Syphilis first hand in the public health clinics of Nairobi as a 4th year medical student)
Pierre Plourde Medical Officer of Health in charge of STD's in Winnipeg


COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

Just A Minute!

DO YOU KNOW THAT

SYPHILIS (Blood disease — Pox) AND GONORRHEA (Clap — gleet — running)

Can Kill You
Can Rob You
Can Cripple You and your (Future) Wife Husband Children

You get Syphilis and Gonorrhea from
Men who are always "on the make." Women who are "easy to get."

Don't Let Them Give Their Disease to *YOU*

BUT:

If you ever have had "sores" or creamy discharge
OR
IF YOU DID "TAKE A CHANCE"
GO TO A GOOD DOCTOR OR CLINIC NOW!

FOR FURTHER INFORMATION
Consult Your
STATE OR LOCAL DEPARTMENT OF HEALTH

Information:

Cadham Provincial Lab:
cadham@gov.mb.ca
Tel. 204-945-6123
www.gov.mb.ca/health (use search word "syphilis")
Public health Canada (search on PHAC-Syphilis)
http://www.phac-aspc.gc.ca/sti-its-surv-epi/rep-rap-2012/rep-rap-3-eng.php