

Strengthening the Primary Care Response to Syphilis

Summary

Primary care is central to Australia's syphilis response. However, missed opportunities for testing, challenges in diagnosis and interpretation, and variable clinician confidence can delay care and place unnecessary pressure on specialist services. Strengthening testing practices, workforce capability and clinical support within primary care represents an important opportunity to improve both patient outcomes and health system performance.

Background

As syphilis notifications continue to increase across Australia, primary care is becoming increasingly important in efforts to improve early detection and treatment. For many people, general practice is the first point of contact with the healthcare system and is well positioned to provide routine sexual health screening, diagnosis and treatment. However, missed opportunities for testing, reliance on risk-based approaches, and challenges in diagnosis and interpretation can contribute to delayed treatment and ongoing transmission. Strengthening primary care capability offers an important opportunity to improve early detection, support timely treatment and reduce pressure on specialist sexual health services. Existing workforce development and clinical support initiatives led by ASHM provide an important foundation for strengthening the primary care response to syphilis.

Missed testing opportunities

Issues with risk-based testing

Risk-based testing is reliant on patient disclosure and clinician assessment of risk. While this approach is widely used, it can result in missed opportunities for diagnosis. There are a number of reasons for this, including:

- Individuals may not recognise behaviours that increase their risk
- Individuals may not perceive themselves to be at risk
- Individuals may choose not to disclose aspects of their sexual history because of concerns about stigma, privacy or discrimination
- Clinicians may feel uncomfortable initiating discussions about sexual health
- Clinicians may have limited experience managing syphilis

As a result, testing opportunities can be missed and infections may remain undiagnosed.

Routine, clinician-initiated and opt-out testing

In contrast, routine and clinician-initiated testing approaches, including opt-out models where appropriate, can reduce reliance on risk assessment and support earlier diagnosis. Syphilis is not always included when individuals present for STI screening or unrelated health issues, resulting in missed opportunities to identify

infection. Embedding comprehensive STI screening approaches, where syphilis is routinely considered alongside infections such as chlamydia, gonorrhoea and HIV, may improve case detection, support earlier treatment and reduce missed opportunities for diagnosis.

Evidence from Australian settings demonstrates that increasing syphilis testing can improve case detection and health outcomes. The introduction of an opt-out testing strategy at an urban Australian sexual health service significantly increased syphilis testing among women and resulted in greater detection of late latent syphilis (1). Similarly, increased syphilis testing among gay, bisexual and other men who have sex with men has been associated with greater detection of asymptomatic early syphilis and a relative reduction in secondary syphilis, highlighting the benefits of earlier diagnosis and treatment (2).

Many general practices already provide high-quality sexual health care and demonstrate the value of routine testing approaches. There is an opportunity to build on these examples and encourage broader adoption of routine, clinician-initiated testing approaches, including opt-out models where appropriate.

Opportunities beyond traditional sexual health settings

Emergency departments and other high-volume healthcare settings represent an underutilised opportunity for syphilis testing. As patients are often already undergoing pathology testing, syphilis screening may be able to be incorporated with minimal additional burden in appropriate circumstances (3).

Earlier diagnosis and treatment can prevent severe outcomes such as congenital syphilis and neurosyphilis, reduce onward transmission, and avoid long-term healthcare costs. These settings may also reach individuals who do not routinely engage with primary care or sexual health services. However, any expansion of testing would require additional resources and workforce support, given the significant pressures already facing many emergency departments.

Clinical challenges in diagnosis and interpretation

Diagnosis of syphilis in general practice can be challenging, particularly for clinicians who do not routinely provide sexual health care or encounter syphilis presentations. Some general practitioners have reported difficulties recognising the diverse clinical presentations of syphilis and interpreting complex serological results, which may contribute to diagnostic uncertainty, delayed diagnosis or delayed treatment.

Diverse presentations

Syphilis is often referred to as the "great imitator" because of its broad and sometimes non-specific clinical presentations. Symptoms may be mild, atypical or mistaken for other conditions such as herpes, and some individuals may have no symptoms at all (4).

Depending on the stage of infection and presenting symptoms, people with syphilis may present to a range of healthcare settings, including general practice, dermatology, neurology, ophthalmology and ENT services. This highlights the importance of syphilis awareness across multiple disciplines to ensure opportunities for diagnosis are not missed.

Challenges in serological interpretation

Interpreting syphilis serology remains a common challenge. Diagnosis often relies on interpretation of multiple test results alongside patient history and previous treatment information. Where this information is incomplete or unavailable, clinicians may experience uncertainty regarding diagnosis and management. Variability in confidence interpreting serology can contribute to delayed diagnosis, delayed treatment, inappropriate referrals and inconsistent clinical management.

Impact on the health system

In some cases, patients are referred to specialist sexual health services for care that could otherwise be managed in general practice. While specialist referral is appropriate in certain circumstances, avoidable referrals place additional pressure on services that are already operating under significant capacity constraints.

Referrals to separate specialist services can be particularly challenging for people who use drugs, individuals experiencing housing instability, migrants, international students and others who may have difficulty navigating multiple services or attending additional appointments.

Where referrals contribute to delays in testing, diagnosis or treatment, opportunities for earlier intervention may be missed. This can increase the risk of ongoing transmission and poorer health outcomes.

Opportunities to strengthen the primary care response

Addressing missed testing opportunities, improving diagnostic confidence and strengthening clinical decision-making represent important opportunities to improve syphilis outcomes. A number of initiatives are already underway to support clinicians and strengthen the capacity of primary care to respond to syphilis.

Workforce development and education

Funded by the Australian Centre for Disease Control, ASHM is currently delivering a [national syphilis workforce development and awareness program](#). Preliminary market research undertaken as part of the program identified a range of challenges that align with the issues outlined in this briefing, including uncertainty regarding when to test for syphilis, difficulties interpreting serological results, misconceptions about syphilis risk, and variable confidence discussing sexual health and assessing risk. The program seeks to address these gaps through workforce education, clinical resources and targeted support for healthcare professionals across a range of settings, with the aim of improving syphilis prevention, testing, diagnosis and treatment in primary care.

Strengthening systems support

In addition to education, clinicians may benefit from greater access to specialist advice services and clinical consultation pathways. Practical systems supports, such as telephone advice services and easily accessible and clear clinical guidance, could help clinicians manage more cases within primary care and reduce avoidable referrals to specialist services.

Recommendations

1. Continue investment in workforce development and education

Support ongoing delivery of nationally coordinated syphilis education initiatives led by ASHM to improve clinician confidence in testing, diagnosis and treatment.

2. Promote routine, clinician-initiated testing

Embed routine and clinician-initiated approaches to syphilis testing within primary care, including opt-out models where appropriate. Where sexual health screening is undertaken, comprehensive STI testing should be considered to reduce missed opportunities for diagnosis.

3. Establish and promote specialist advice services

Provide readily accessible telephone and clinical support services to assist GPs with testing, interpretation of results and treatment decisions.

4. Reduce avoidable referrals and delays in care

Strengthen primary care capability to ensure more patients can receive timely diagnosis and treatment within general practice while preserving specialist capacity for complex cases.

References

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