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Title

In Response to the Letter From Martinez et al. Risk Factors for Syphilis at a Large Urban Emergency Department

Permalink

<https://escholarship.org/uc/item/4ng3r5sq>

Journal

Sexually Transmitted Diseases, 49(10)

ISSN

0148-5717

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[et al.](#)

Publication Date

2022-10-01

DOI

10.1097/olq.0000000000001684

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Peer reviewed

1 **Letter to the Editor: In response to the letter from Martinez et al.**

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3 **Risk Factors for Syphilis at a Large Urban Emergency Department**

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1 Dear Editor,

2 We would like to thank Martinez et al. for providing the opportunity to clarify and
3 expand our commentary on our previously published paper¹.

4 Syphilis testing costs vary by type of testing required (i.e., *T. pallidum* antibody, rapid
5 plasma regain, *T. pallidum* particle agglutination) and insurance status. Emergency department
6 (ED) providers followed a script provided in the best practice alert (BPA) advisory that helped
7 standardize screening and comply with ethical regulations. Patients were informed of the
8 intention to test and had the opportunity to decline testing. Laboratory testing was financed by
9 charging the patient's insurance, a billing strategy employed by similar screening programs and
10 studies². Since co-testing for syphilis when testing for other STIs such as HIV or
11 gonorrhea/chlamydia is standard of care, insurance should have covered this cost in almost all
12 cases^{3,4}. We are not aware of any cases where insurance would did not pay for the test alongside
13 other STI testing.

14 In the paper under discussion, undomiciled housing status, history of HIV, history of
15 tobacco use and history of illicit drug use were identified as risk factors for syphilis in an ED
16 population¹. Martinez et al. were interested to know the baseline characteristics and risk factor
17 profiles for the children included in our study. Of the original 1,974 patients included in our
18 study, only 69 (3.5%) were younger than 18 years (range: 7 months to 17 years). Most patients in
19 this age group were female (47/69, 68%) and non-Hispanic Black (21/69, 30%). Only two of
20 these patients tested positive. Both patients who tested positive were Non-Hispanic, African
21 American males and their ages were 15 and 17 years. Due to a small sample size, a formal risk
22 factor analysis for this age group is not practical. Only one of these two patients possessed any of

1 our previously described ED risk factors for syphilis infection (history of tobacco use)¹. Further
2 studies are needed to clarify syphilis risk factors in a pediatric ED population.

3 Martinez et al. commented on the possibility of the COVID-19 pandemic influencing ED
4 visits for STIs, which could lead to an underestimation of syphilis diagnoses. While we
5 acknowledge this possibility, the goal of the study was not to assess infection prevalence, but
6 rather to assess risk factor profiles. While the above may affect these results, we believe that the
7 21-month study period provides enough data to overcome this potential bias.

8 Martinez et al. inquire as to the process for patient follow-up. While we used de-
9 identified datasets, each patient had a study-specific identifier that program Patient Navigators
10 (PNs) could cross-reference with a separately stored database that contained patient contact
11 information. PNs were then able to contact patients to schedule follow-up or contact local health
12 departments to inquire about follow-up.

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