Syphilis (Aatishak): Complete Modern and Unani Understanding of Causes, Stages, Symptoms, Diagnosis, Complications and Treatment

A Comprehensive Patient-Friendly Guide to Syphilis, Sexual Health, Pregnancy, Fertility and Responsible Integrative Care

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Introduction

In my clinical work in sexual disorders and infertility, I regularly meet patients who are frightened when they hear the word **syphilis**. Some have noticed a genital ulcer. Others have no symptoms at all but received a reactive blood test during an STI screening, infertility investigation, antenatal check-up or routine health examination.

One of the most important things I explain to patients is that **syphilis is a serious infection, but it is also a preventable and curable bacterial disease when correctly diagnosed and appropriately treated**.

The infection is caused by a very thin, spiral-shaped bacterium called ***Treponema pallidum***. Without treatment, syphilis can remain in the body for years and may progress through several clinical stages. It can affect the skin, nervous system, eyes, ears, cardiovascular system and other organs. During pregnancy, it can cross the placenta and cause congenital syphilis, stillbirth or other severe outcomes.

The latest World Health Organization fact sheet, published in May 2025, estimates that approximately **8 million adults aged 15–49 acquired syphilis during 2022**. WHO also emphasizes that many infections are asymptomatic or unrecognized.

For me, the most important message is therefore not to panic and not to hide the condition. **Get properly tested, determine the stage, receive the correct treatment and complete follow-up.**

From the perspective of Unani medicine, syphilis has historically been discussed as **Aatishak**. Classical Unani physicians developed extensive concepts regarding constitutional imbalance, *Fasad-e-Dam*, purification and supportive care for the manifestations of this disease. These

concepts have historical and complementary value, but modern microbiology has now established that syphilis is caused by *Treponema pallidum*. Therefore, responsible contemporary Unani practice should work **alongside—not instead of—proven penicillin treatment** for active syphilis.

What Is Syphilis?

Syphilis is a **systemic bacterial sexually transmitted infection**.

The term systemic means that although the infection may begin at a local site—such as the penis, vagina, vulva, anus, rectum, lips or mouth—the organism can subsequently spread throughout the body.

The infection may remain unnoticed because the first ulcer is often painless, and later symptoms may disappear even though the organism remains inside the body.

CDC therefore divides syphilis into clinical stages because the patient's stage determines treatment, follow-up and assessment for complications. Primary disease typically involves a chancre, secondary disease can produce generalized skin and mucosal manifestations, latent disease has positive serology without clinical manifestations, and tertiary disease may produce cardiovascular or gummatous complications. Importantly, **neurosyphilis, ocular syphilis and otosyphilis can occur at any stage**, not only in late disease.

What Causes Syphilis?

Syphilis is caused by ***Treponema pallidum subspecies pallidum***.

This bacterium belongs to a group known as spirochetes because of its thin, spiral shape.

Unlike many bacteria that remain confined to one tissue, *T. pallidum* can penetrate mucous membranes or damaged skin, enter lymphatic and blood circulation and disseminate throughout the body.

The body's immune response controls some manifestations of infection, which is why sores and rashes may disappear spontaneously. But disappearance of symptoms does **not** necessarily mean elimination of the organism.

This ability to enter symptom-free phases is one reason syphilis has historically been called the **"great imitator."**

How Is Syphilis Transmitted?

Syphilis is mainly transmitted through **direct contact with an infectious syphilitic lesion during vaginal, anal or oral sexual contact**.

The lesion may be present on the penis, vulva, vagina, cervix, anus, rectum, mouth or lips. A person may not notice the lesion, particularly when it is inside the vagina, rectum or mouth.

Syphilis can also pass from an infected pregnant woman to her unborn baby through the placenta.

WHO confirms sexual and pregnancy-related transmission and emphasizes that syphilis can be transmitted during oral, vaginal and anal sex.

Syphilis is **not normally spread through casual social contact**, such as sitting beside someone, sharing ordinary food, hugging, using the same toilet or using ordinary household objects.

How Long After Exposure Does Syphilis Appear?

The first manifestation usually develops several weeks after infection.

WHO describes the primary stage as appearing after an average interval of approximately **21 days**, although the exact incubation period varies between individuals.

This delay can make it difficult for patients to identify exactly when or from whom they acquired the infection.

It is therefore inappropriate to make assumptions about the timing of transmission simply from the date a sore was first noticed.

The Different Stages of Syphilis

Understanding the stages is central to understanding this disease.

Primary Syphilis

Primary syphilis usually begins with an ulcer called a **chancre** at the site where *Treponema pallidum* entered the body.

Classically, a syphilitic chancre is round or oval, firm and painless. However, real clinical disease does not always follow textbook descriptions. CDC notes that primary syphilis can occasionally produce **multiple, atypical or even painful lesions**.

Nearby lymph nodes may become enlarged.

The ulcer can occur on visible genital skin, but it may also occur inside the vagina, cervix, rectum, anus or mouth, where it is easily missed.

The chancre usually heals even without treatment.

This spontaneous healing is dangerous because the patient may think:

“The wound has disappeared, so the disease is cured.”

The organism may already have disseminated into the bloodstream.

Secondary Syphilis

If primary syphilis remains untreated, systemic manifestations may subsequently develop.

Secondary syphilis reflects widespread dissemination of the organism.

The characteristic feature is a skin rash, often involving multiple parts of the body. The rash may affect the **palms of the hands and soles of the feet**, which is an important clinical clue.

Other manifestations can include generalized lymph-node enlargement, mucous patches in the mouth, broad moist lesions known as **condylomata lata**, fever, tiredness, sore throat, headache, muscle aches and patchy hair loss.

CDC recognizes rash, mucocutaneous lesions and generalized lymphadenopathy among typical manifestations of secondary syphilis.

Again, symptoms may disappear without treatment.

The disappearance is not proof of microbiological cure.

Latent Syphilis

After the early manifestations disappear, the infection may enter the **latent stage**.

During latent syphilis, there are no obvious clinical signs of primary or secondary disease, but blood tests remain reactive.

CDC defines early latent syphilis as latent infection acquired within the preceding year; patients who cannot meet criteria for infection within that period are categorized as late latent or latent syphilis of unknown duration. WHO uses somewhat different time definitions in some international treatment frameworks. Therefore, clinicians should follow the staging terminology in the guideline applicable to their setting.

Latent disease is important because a patient may feel completely normal while *T. pallidum* remains within the body.

A pregnant woman with latent syphilis can also transmit infection to her fetus.

Tertiary Syphilis

Only a proportion of untreated people progress to tertiary disease, but when it occurs it can be severe.

Tertiary syphilis may appear years after the original infection and can involve the cardiovascular system or produce inflammatory masses called **gummas**.

CDC describes tertiary manifestations including cardiovascular syphilis, gummatous disease and certain late neurological or psychiatric presentations.

The key lesson for patients is that treatment should occur **before irreversible organ damage develops**.

Neurosyphilis

Syphilis involving the central nervous system is called **neurosyphilis**.

An important modern correction to older teaching is that neurosyphilis is not exclusively a late complication.

T. pallidum can involve the nervous system during **any stage of syphilis**.

Possible manifestations include meningitis, cranial-nerve abnormalities, altered mental state, sensory problems, motor weakness and stroke-like presentations. Late disease may cause serious neurological syndromes such as tabes dorsalis or general paresis.

Patients with neurological symptoms require specialist evaluation, and cerebrospinal fluid analysis may be necessary.

Ocular Syphilis

Syphilis can affect almost any part of the eye.

Possible manifestations include uveitis, optic neuritis, neuroretinitis and retinal inflammation.

Ocular syphilis can occur at any stage and can lead to **permanent loss of vision** if diagnosis or treatment is delayed.

CDC recommends urgent ophthalmological assessment when ocular syphilis is suspected and advises treating confirmed ocular disease using the neurosyphilis regimen, even when cerebrospinal fluid results are normal.

Anyone with reactive syphilis tests who develops new visual blurring, eye pain, reduced vision or other significant ocular symptoms should therefore seek prompt medical attention.

Otosyphilis

Syphilis can also affect the auditory and vestibular systems.

Otosyphilis may cause **hearing loss, ringing in the ears, dizziness or vertigo**.

Hearing loss can be sudden and may affect one or both ears.

CDC warns that otosyphilis can cause permanent hearing loss and recommends specialist assessment and treatment using the same antimicrobial regimen as neurosyphilis.

Syphilis During Pregnancy

Syphilis during pregnancy is one of the most important preventable causes of poor pregnancy and neonatal outcomes.

The infection can cross the placenta and infect the developing fetus.

WHO reports that syphilis in pregnancy that is untreated, treated late or treated with the wrong antibiotic can result in an adverse birth outcome in approximately **50–80% of affected pregnancies**.

Possible consequences include miscarriage, stillbirth, premature birth, neonatal death and congenital syphilis.

This is why antenatal syphilis screening is so important.

WHO recommends screening during prenatal care, and India's NACO programme also emphasizes **universal HIV and syphilis testing of pregnant women, early treatment and appropriate management of exposed infants**.

Congenital Syphilis

Congenital syphilis occurs when an infected pregnant woman transmits *Treponema pallidum* to her baby.

A newborn may look healthy initially and still be infected.

Possible manifestations include rash, enlargement or inflammation of organs, anaemia, bone abnormalities and neurological disease. Later consequences can include hearing impairment, visual problems and developmental abnormalities.

WHO emphasizes that **maternal diagnosis and appropriate penicillin treatment are essential for preventing congenital syphilis**.

Infants born to mothers with inadequately treated syphilis require structured neonatal evaluation and, when indicated, penicillin treatment and serological follow-up.

Does Syphilis Cause Infertility?

Patients frequently ask me this because my clinical practice focuses on sexual disorders and infertility.

Syphilis is **not among the most common direct causes of tubal infertility in women or obstructive infertility in men**. Chlamydia and gonorrhoea have much stronger established relationships with pelvic inflammatory disease and tubal damage.

However, untreated syphilis remains important to reproductive medicine because it can have profound consequences for **pregnancy, fetal health and congenital infection**.

Rare reproductive-organ involvement can occur, but patients should not automatically assume that a positive syphilis test is the cause of a low sperm count or inability to conceive.

When infertility is present, I prefer a complete evaluation of both partners rather than attributing the problem to one historical infection without evidence.

Syphilis and HIV

Syphilis and HIV frequently intersect clinically because both may be transmitted through sexual exposure.

Ulcerative STIs can also facilitate HIV acquisition by disrupting the protective mucosal barrier.

CDC recommends that **all patients diagnosed with syphilis should be tested for HIV**. Patients who are HIV-negative but remain at meaningful ongoing risk should also be counselled about appropriate HIV-prevention strategies such as PrEP where available and suitable.

People living with HIV can still be successfully treated for syphilis, but careful clinical and serological follow-up is important.

How Is Syphilis Diagnosed?

No single symptom is reliable enough to diagnose syphilis.

A proper diagnosis usually combines clinical examination with laboratory testing.

Two broad types of blood tests are used.

Nontreponemal Tests: VDRL and RPR

The most familiar are **VDRL** and **RPR**.

These tests detect antibodies produced in response to tissue damage associated with infection rather than antibodies uniquely specific to *T. pallidum*.

They are valuable because they can be reported quantitatively as a **titre**, for example 1:8, 1:16 or 1:32.

The titre can then be followed after treatment.

A fourfold change corresponds to two dilution steps—for example, 1:32 decreasing to 1:8.

Nontreponemal tests can occasionally produce false-positive results in situations unrelated to syphilis, so confirmation is generally necessary.

Treponemal Tests

Treponemal tests detect antibodies that specifically recognize *Treponema pallidum*.

Examples include TPPA/TP-PA and various enzyme or chemiluminescent immunoassays.

These tests are excellent for supporting diagnosis but often remain reactive for very long periods—even after successful treatment.

Therefore:

A positive treponemal test after treatment does not automatically mean treatment failed.

This is an extremely common source of unnecessary anxiety among patients.

The **quantitative RPR or VDRL trend**, together with clinical history and examination, is generally more useful for monitoring response.

Traditional and Reverse-Sequence Testing

Laboratories may use either a traditional sequence or a reverse sequence.

In the traditional approach, an RPR or VDRL is performed first and a reactive result is confirmed with a treponemal test.

Some laboratories now begin with an automated treponemal test and then perform quantitative RPR or VDRL.

CDC recommends that when a treponemal screening test is positive but the nontreponemal test is negative, a second different treponemal assay—preferably TP-PA or an assay using different antigens—can help clarify the result.

This is why patients should not interpret a single “positive” report without understanding what type of syphilis test was performed.

Can Syphilis Tests Remain Positive After Cure?

Yes.

Treponemal tests often remain reactive for years and frequently for life.

Nontreponemal titres generally fall after successful treatment, but some patients remain persistently reactive at a low titre—the so-called **serofast state**.

This does not necessarily mean the organism remains active.

Treatment history, stage, baseline titre, clinical symptoms, reinfection risk and follow-up titre must all be considered.

Repeatedly treating a patient solely because “the test is still positive” can therefore be inappropriate if the type of test and previous treatment are not understood.

Modern Treatment of Syphilis

The cornerstone of syphilis treatment remains **penicillin**.

WHO states that syphilis is curable and identifies benzathine penicillin G as first-line treatment. CDC similarly describes parenteral penicillin G as the preferred therapy at all stages, with the specific preparation and duration determined by stage and clinical manifestation.

The following table summarizes major CDC regimens for adults. It is included for medical education and **should not be used for self-treatment**.

Clinical situation	Standard guideline approach
Primary syphilis	Benzathine penicillin G 2.4 million units IM once
Secondary syphilis	Benzathine penicillin G 2.4 million units IM once
Early latent syphilis	Benzathine penicillin G 2.4 million units IM once
Late latent or unknown-duration syphilis	Total 7.2 million units: 2.4 million units IM weekly for 3 doses

Clinical situation	Standard guideline approach
Tertiary syphilis without neurosyphilis and with appropriate CSF assessment	2.4 million units IM weekly for 3 doses
Neurosyphilis, ocular syphilis or otosyphilis	Aqueous crystalline penicillin G 18–24 million units/day IV for 10–14 days
Syphilis during pregnancy	Stage-appropriate penicillin therapy; penicillin is essential

These regimens reflect CDC guidance; national protocols and individual circumstances should determine actual prescribing.

Why the Type of Penicillin Matters

Patients sometimes think that “any penicillin injection” will treat syphilis.

That is not correct.

Different penicillin preparations behave differently in the body.

Benzathine penicillin G provides prolonged blood concentrations suitable for uncomplicated early or latent syphilis but does not achieve the cerebrospinal-fluid concentrations required for neurosyphilis.

Neurosyphilis requires an appropriate intravenous regimen.

CDC specifically warns that correct penicillin preparation, dose and duration must be selected according to the disease stage and site of involvement.

This is why syphilis treatment should be clinician-directed.

Penicillin Allergy

People who report penicillin allergy need careful assessment.

For certain nonpregnant patients, alternative antimicrobial regimens can sometimes be considered, but the evidence is generally less extensive than for penicillin and follow-up becomes particularly important.

Pregnancy is different.

CDC states that **parenteral penicillin G is the only therapy with documented efficacy for treating syphilis during pregnancy and preventing fetal infection**. A pregnant patient with a

genuine penicillin allergy should therefore generally undergo specialist-directed desensitization and receive penicillin.

Patients should never substitute an herbal treatment simply because they believe they are allergic to penicillin.

Jarisch–Herxheimer Reaction

Some patients feel temporarily worse soon after syphilis treatment.

This may be a **Jarisch–Herxheimer reaction**.

It usually occurs within the first 24 hours after starting effective treatment and may cause fever, headache, muscle aches and temporary worsening of skin lesions.

Importantly, this is **a treatment-associated inflammatory reaction and is not the same as an allergy to penicillin**.

Pregnant women deserve particular attention because the reaction can be associated with uterine contractions or fetal distress. However, concern about this reaction should **not delay necessary syphilis treatment**.

Follow-Up After Treatment

Treatment is not complete simply because the injection has been given.

Follow-up serology is important.

CDC recommends clinical and serological follow-up at approximately **6 and 12 months** after treatment for primary and secondary syphilis.

For latent disease, quantitative nontreponemal testing is generally repeated at **6, 12 and 24 months**.

A sustained fourfold increase in RPR/VDRL titre after treatment may indicate reinfection or treatment failure and warrants reassessment.

A patient's expected titre decline depends on the disease stage, baseline titre and whether they have previously been treated.

Why Reinfection Is Common

Successful syphilis treatment does **not** create permanent immunity.

A person can become infected again.

This is why partner management is essential.

If only one partner is treated while another infectious partner remains untreated, the patient may be exposed again and later believe that the original medicine "failed."

CDC recommends clinical and serological evaluation of sexual partners and provides specific presumptive-treatment recommendations according to when exposure occurred in relation to primary, secondary or early latent disease.

Modern STI care is therefore not simply **"treat the patient."**

It is:

diagnose the patient, treat correctly, evaluate partners, reduce transmission and perform follow-up.

Syphilis According to Unani Medicine

Syphilis is historically recognized within formal Unani literature.

The Unani term commonly used is **Aatishak (Ātishak)**.

The Central Council for Research in Unani Medicine notes that diseases such as syphilis and gonorrhoea were incorporated into later Unani literature and their management described according to Unani principles.

Classical explanations were developed centuries before the discovery of *Treponema pallidum*. Physicians therefore interpreted the disease through the theoretical framework available at the time.

Classical Unani Understanding of Aatishak

Unani medicine traditionally understands health in relation to balance among the **Akhlat**—the four humours—and the individual's **Mizaj**, or temperament.

In Aatishak, classical physicians described concepts such as **Fasad-e-Dam**, indicating pathological disturbance or corruption of blood, together with abnormal morbid matter and inflammatory manifestations.

The skin eruptions, ulcers and systemic symptoms of syphilis were therefore interpreted through a humoral and constitutional framework rather than through microbiology.

The therapeutic objectives historically included concepts such as **Tasfiya-e-Dam**, traditionally described as purification of the blood; **Tanqiya**, elimination of abnormal matter; **Tadeel-e-Mizaj**, restoration of temperamental balance; and supportive measures directed toward affected organs and general strength.

These concepts remain relevant to the **history and philosophy of Unani medicine**, but they should not be presented as explanations that replace the known bacterial cause of syphilis.

Historical Unani Medicines for Aatishak

Traditional Unani pharmacopoeias describe multiple medicines for Aatishak.

For example, a CCRUM publication reports that **Habb-e-Paan** appears in the National Formulary of Unani Medicine and has historically been indicated for Aatishak and *Fasad-e-Dam*.

However, there is an important modern safety consideration.

The same standardized formulation includes **white oxide of arsenic** among its ingredients. Other historical formulations may contain mercury or other mineral substances.

Therefore, I strongly advise patients **not to self-medicate with historical herbo-mineral formulations for syphilis**.

Pharmacopoeial existence or historical use does not prove that such a formulation is safer or more effective than modern penicillin treatment.

This distinction is extremely important for responsible twenty-first-century Unani medicine.

The Role of Chobchini and Ushba in Unani Tradition

Classical and later Unani literature frequently refers to plants in the *Smilax* group, including **Chobchini** and **Ushba**, within traditional *Musaffi-e-Dam* approaches.

Historically, these medicines became associated with skin disease, venereal disorders and chronic constitutional complaints.

Modern laboratory research into *Smilax* species has identified flavonoids, saponins and antioxidant or anti-inflammatory constituents.

However, pharmacological activity in a laboratory is not the same as demonstrating eradication of ***Treponema pallidum*** in humans.

There are not high-quality modern clinical trials showing that Chobchini or other Unani herbs can replace benzathine penicillin for microbiological cure of syphilis.

Therefore, I regard such medicines—when clinically appropriate—as belonging to the **supportive Unani domain, not as substitutes for curative antibiotic treatment**.

How Unani Medicine Can Be Useful in Syphilis Care

This is where I believe the Unani system has a responsible and potentially valuable role.

Once the active infection has been diagnosed and adequate pathogen-directed treatment has been given, patients may still require broader care.

Unani medicine traditionally gives considerable attention to **diet, digestion, constitution, sleep, general weakness, recovery from illness and individualized lifestyle management**.

A patient who has completed appropriate syphilis treatment may still experience anxiety, fatigue or other nonspecific symptoms requiring proper evaluation.

In selected patients, individualized Unani supportive care can be considered for **general convalescence and overall wellbeing**, provided it does not interfere with antimicrobial therapy or required medical follow-up.

For me, this represents the strongest form of integrative medicine: **penicillin eliminates the proven bacterial infection; appropriate Unani care may support the patient as a whole where there is a reasonable clinical indication.**

Unani Medicine Must Not Be Used to Hide Persistent Syphilis

One danger is treating a rash or ulcer until it looks better and assuming the infection has disappeared.

Syphilitic lesions can heal naturally even without adequate therapy.

Therefore, symptomatic improvement following any medicine—Unani or modern—does not automatically demonstrate eradication of *T. pallidum*.

The correct evidence of successful management comes from appropriate antimicrobial treatment combined with clinical and serological follow-up.

This is particularly important because inadequately treated syphilis may enter a latent stage while the patient feels completely normal.

Dr. Nizamuddin Qasmi's Approach to Syphilis at Saira Health Care

At **Saira Health Care**, my approach to a patient with suspected or confirmed syphilis is based on accurate diagnosis, safety, confidentiality and protection of long-term sexual and reproductive health.

I do not believe in treating syphilis merely as a genital sore.

First, I consider whether the laboratory diagnosis is reliable. A reactive RPR or VDRL must be interpreted alongside an appropriate treponemal test, previous treatment history and clinical findings.

Second, I determine the probable **stage of disease**, because treatment requirements differ between early infection, late latent disease and neurological or ocular involvement.

Third, active syphilis is treated or appropriately referred for **evidence-based penicillin therapy**.

Fourth, HIV and other STI assessment is considered according to the patient's history and risk.

Fifth, the patient's sexual partner or partners require appropriate counselling, testing and treatment when indicated.

Sixth, quantitative RPR or VDRL follow-up is planned instead of declaring cure simply because the visible lesion has disappeared.

Finally, where a patient would benefit from constitutional, dietary or convalescent support, I may consider a carefully individualized **Unani supportive approach**, while ensuring that it never replaces the antimicrobial treatment necessary to eliminate syphilis.

This is what I consider responsible integration of **Unani knowledge with modern sexual medicine**.

Contribution of Saira Health Care in Sexual Disorders and Infertility

Sexually transmitted infections are often surrounded by fear, stigma and secrecy.

Many patients do not approach a qualified physician immediately. Some buy medicine from a pharmacy without testing. Others take repeated herbal preparations because they are worried that their family or partner might discover the problem.

At **Saira Health Care**, one of our goals is to make sexual-health consultation professional, confidential and understandable.

Our work in sexual disorders and infertility includes helping patients differentiate infection from other genital and sexual conditions, understand laboratory reports, recognize the importance of partner care and protect reproductive health.

Syphilis is particularly suitable for this educational approach because it demonstrates how misleading symptoms can be.

An ulcer may heal without cure. A patient may enter latency without symptoms. A treponemal blood test may remain positive after successful treatment. And reinfection can occur even after appropriate therapy.

These concepts must be explained clearly rather than simply handing the patient a prescription.

Syphilis and Sexual Dysfunction

A diagnosis of syphilis can also affect psychological and sexual wellbeing.

Some patients become afraid of sexual contact even after successful treatment. Others develop guilt, relationship stress, fear of infertility or performance anxiety.

These concerns should not be dismissed.

Sexual health includes physical, psychological and relationship wellbeing.

At Saira Health Care, I believe a patient should be counselled about when sexual activity can safely resume, how partners should be managed, how reinfection can be prevented and whether any persistent sexual dysfunction requires separate evaluation.

Syphilis treatment and sexual-function treatment are not the same thing.

Is Syphilis Completely Curable?

Yes, syphilis is a curable bacterial infection when the correct antimicrobial treatment is used.

However, the word “cure” requires an important clarification.

Antibiotics can eradicate *T. pallidum*, but treatment may not reverse **permanent damage that already occurred before therapy**, such as advanced neurological, cardiovascular, auditory or visual injury.

This is why early diagnosis matters.

It is much better to cure syphilis before organ damage develops than to eradicate the organism after irreversible injury has occurred.

Can Syphilis Come Back After Treatment?

There are two major possibilities when a patient's tests or symptoms change after treatment.

One is **reinfection**, meaning the patient acquired syphilis again following another exposure.

The other is possible treatment failure, which is less common after correct stage-appropriate penicillin therapy.

A sustained fourfold rise in RPR/VDRL titre or recurrence of compatible symptoms requires clinical assessment.

This is why follow-up tests should be compared with the patient's **baseline quantitative titre**, not merely labelled “positive” or “negative.”

Does a Positive VDRL Always Mean Syphilis?

No.

RPR and VDRL are nontreponemal tests and can occasionally be reactive for reasons other than syphilis.

Pregnancy, autoimmune conditions and some infections are among situations in which biological false-positive nontreponemal tests can occur.

Diagnosis normally requires confirmation using an appropriate **treponemal test** and interpretation in clinical context.

Similarly, a positive treponemal test may represent previously treated infection rather than newly active disease.

This is one reason laboratory reports should be interpreted by a qualified clinician.

Can Syphilis Be Detected Very Soon After Exposure?

Not always.

Antibodies require time to develop after infection.

A patient tested very early after exposure may therefore have a negative serological result despite incubating infection.

When exposure was recent and clinically significant, repeat testing or presumptive treatment may be necessary according to professional guidance and the characteristics of the exposure.

CDC notes that recent sexual contacts of patients with primary, secondary or early latent syphilis may sometimes require presumptive treatment even if initial serology is negative.

Prevention of Syphilis

Syphilis prevention depends on reducing exposure and detecting infection early.

Consistent and correct condom use reduces the risk substantially, although it cannot guarantee complete protection because an infectious lesion may be present on skin outside the area covered by the condom.

WHO identifies condoms, risk-based regular testing, early treatment and appropriate partner care as major prevention measures.

People at increased risk should undergo periodic screening according to local recommendations.

Pregnancy screening is particularly important because timely maternal treatment can prevent congenital disease.

When Should a Patient Seek Urgent Medical Attention?

Most uncomplicated syphilis does not require emergency treatment, but certain manifestations deserve prompt assessment.

A patient with known or suspected syphilis who develops sudden visual disturbance, reduced vision, severe eye pain, new hearing loss, significant vertigo, neurological weakness, confusion, severe headache with neurological signs or stroke-like symptoms requires urgent medical evaluation.

Pregnant patients with reactive syphilis testing should also receive prompt treatment rather than waiting for symptoms.

After treatment during pregnancy, fever, contractions or decreased fetal movement should prompt obstetric assessment because of the possible Jarisch–Herxheimer reaction.

Frequently Asked Questions About Syphilis

Can syphilis disappear by itself?

The **symptoms can disappear**, but untreated infection may remain. A chancre can heal and a rash can resolve while *Treponema pallidum* persists in the body.

Is syphilis curable?

Yes. Appropriate penicillin treatment can cure the infection.

Can I get syphilis again after being cured?

Yes. Previous infection does not provide reliable immunity against future reinfection.

Can syphilis be transmitted through oral sex?

Yes. Syphilis may be transmitted through oral, vaginal or anal sexual contact.

Does every syphilis sore hurt?

No. The classic primary chancre is painless, but CDC notes that atypical and occasionally painful lesions occur.

Can syphilis affect the brain?

Yes. Neurosyphilis may occur at any stage and can cause neurological complications.

Can syphilis damage eyesight?

Yes. Ocular syphilis can cause serious inflammation and permanent visual loss if not treated promptly.

Can it affect hearing?

Yes. Otosyphilis may cause tinnitus, vertigo and sensorineural hearing loss.

Is syphilis dangerous during pregnancy?

Yes. Untreated maternal syphilis can cause congenital infection, miscarriage, stillbirth or neonatal complications. Penicillin treatment is essential.

Does a positive TPHA or treponemal test mean I still have active syphilis?

Not necessarily. Treponemal tests frequently remain reactive after adequate treatment. The previous treatment history and quantitative RPR/VDRL response must be reviewed.

Can Unani medicine cure syphilis without penicillin?

Current scientific evidence does **not** establish Unani medicine as a replacement for penicillin in microbiological eradication of *Treponema pallidum*. Historical Unani medicine has recognized Aatishak and developed multiple traditional approaches, but active syphilis should receive established antibiotic treatment.

Is Unani medicine therefore useless in syphilis?

No. Qualified Unani medicine may have a **supportive role** in appropriately selected patients for diet, constitution, convalescence and general wellbeing after or alongside necessary medical treatment. Its role should be complementary rather than a substitute for proven antimicrobial cure.

My Final Message to Patients

Whenever a patient comes to me with syphilis, I tell them that this disease should be respected—but it should not be feared unnecessarily.

We have reliable tests.

We have highly effective treatment.

And when syphilis is diagnosed and treated at the correct time, serious complications can often be prevented.

The greatest danger is not the diagnosis itself. The greatest danger is **delaying treatment because the sore disappeared, hiding the diagnosis from medical professionals, repeatedly self-medicating, or relying on an unproven "permanent cure."**

As a physician trained in the Unani system and focused on **sexual disorders and infertility**, I respect the historical literature of Aatishak. Unani medicine teaches us to look at constitution, diet, lifestyle, recovery and the person as a whole. Formal CCRUM literature confirms that syphilis was historically incorporated into Unani medical knowledge.

At the same time, contemporary science has identified *Treponema pallidum* and has given us a treatment capable of eradicating this organism.

Therefore, my approach is clear:

Diagnose syphilis correctly. Determine its stage. Treat the bacterium with appropriate penicillin. Evaluate HIV and other relevant infections. Manage partners. Follow quantitative serology. Investigate neurological, eye or hearing symptoms promptly. Then use individualized Unani supportive care where it can safely contribute to overall recovery and reproductive wellbeing.

This is the type of integrative medicine I believe best protects the patient.

At **Saira Health Care**, our objective is not only to treat an infection but also to help patients understand their condition, overcome unnecessary fear, protect their partners and preserve their long-term sexual and reproductive health.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi is the **Founder & Chief Physician of Saira Health Care**, with a focused clinical practice in **Sexual Disorders & Infertility**.

His listed qualifications are **BUMS from Hamdard University, Delhi; MD; CGO; Certificate in Infertility from MGBIMS, Delhi; Certificate in Urology – London, UK; Masters in Male Infertility by MasterHealthPro (HealthPro); and Integrated Sexual and Reproductive Health (ISRH, UNFPA).**

His clinical approach emphasizes confidential patient communication, appropriate modern diagnostic assessment, evidence-based management of infections, reproductive-health evaluation and responsible integration of Unani supportive medicine where appropriate.

For further information, patients may visit the **Saira Health Care** website.

Medical Disclaimer

This article is intended for **general health education and public awareness**. It does not constitute an individual diagnosis, prescription or substitute for medical examination.

Syphilis is a bacterial sexually transmitted infection that requires appropriate antimicrobial treatment. **Unani, herbal or complementary medicines should not be used to delay or replace stage-appropriate penicillin therapy.** Patients with neurological symptoms, eye symptoms, hearing changes, pregnancy or suspected congenital syphilis require appropriate specialist assessment.

The discussion of Unani medicines reflects their **traditional and historical use**. Historical Unani formulations may include mineral ingredients with significant safety considerations; they should not be self-prescribed. Current evidence does not establish traditional formulations as microbiological substitutes for penicillin in the treatment of active syphilis.