

VAGINAL INFECTIONS: BACTERIAL VAGINOSIS

Diagnosis

In Sandyford services we diagnose BV in women who have a symptomatic vaginal discharge and Gram-stained evidence of abnormal vaginal flora by the modified Hay-Ison criteria (*Sex Trans Inf* 2002;**78**:413-415)

Where microscopy is not available. The diagnosis is made on history of increased grey discharge which usually has an offensive smell, and a raised pH >5 of vaginal secretions. The local lab will do a Gram stain from the HVS for later confirmation.

Women with abnormal vaginal discharge should have a vaginal charcoal swab sent for culture.

Grade (Hay –Ison)	Sandyford lab	Morphology
0	-	Epithelial cells only
I	Normal	Lactobacillus
II	Int	Reduced lactobacillus with mixed bacteria
III	Abnormal	Few or absent lactobacilli. Greatly increased numbers of Gram-variable rods and other morphotypes, including <i>Mobiluncus</i> spp
IV	-	Epithelial cells covered with Gram+ cocci only

Treatment

Offer treatment to:

- Symptomatic women and those undergoing vaginal procedures (eg TOP, transvaginal hysterectomy, Caesarean section)

Metronidazole 400 mg bd for 5 days (95% response)

OR

Metronidazole 2g stat (85% response)

Warn to avoid alcohol

NB High dose oral Metronidazole may affect the taste of breast milk in lactating mothers

2nd Line

- Clindamycin cream 2% once daily for 7 days (93% response)
(NB expensive + may mask coexistent gonorrhoea; weakens condoms)
- Metronidazole intravaginal gel 0.75% od 5 days

- Clindamycin 300mg oral bd for 7 days (*NB make aware of risk of Pseudomembranous colitis and as small amounts can enter breast milk, use intravaginal cream in lactating women*)
- Tinidazole 2G oral stat
- All 70-80% 4 week cure rate
- Asymptomatic pregnant women with a previous history of pre-term labour = Clindamycin 300mg BD x one week

Partner Participation

Some work suggests that male partners of women with BV can present with NSU.

Follow-Up

If other microscopy negative and no other infection suspected clinically, not required (other results can be txted). (see below for pregnancy)

Recurrences / Relapses

Women with recurrent discharge are best managed in Sandyford Central with access to wet film and gram stain microscopy.

- 1 Confirm diagnosis and refer into a consultant clinic.
- 2 Advice on avoiding douching, shower gel, bath foam etc. .
- 3 Possible strategies include:
 - Metronidazole 400mg bd for 3 days at start and end of period
 - Metronidazole gel 0.75% for 10 days then twice weekly for 3-6 months
- 4 No good evidence that treatment of male or female partners of value (although BV commonly found in female partners of women with BV).

Bacterial Vaginosis in Pregnancy

- There is increasing evidence that BV is associated with detrimental pregnancy outcomes such as pre-term labour and low birth weight. Asymptomatic pregnant women do not require treatment routinely
- BV is also associated with post-TOP endometritis and PID and there is RCT evidence that treatment of BV reduces TOP complications
- Women who have a **history of preterm birth or second trimester foetal loss** may be screened for BV and, if BV present, treated with clindamycin 300mg bd for 7 days. Recently, a UK-based RCT found that treating asymptomatic women with BV or intermediate flora detected on Gram stain with oral clindamycin produced a five-fold reduction in late miscarriage and also in spontaneous preterm birth. The use of clindamycin cream to treat BV in the second trimester of pregnancy has not produced a reduction in preterm birth in two small studies.
- A large meta-analysis has shown no evidence of teratogenicity from use of metronidazole in women during the first trimester but you should avoid high dose stat doses of metronidazole in pregnancy.