

Bacterial Vaginosis

Introduction

Aetiology

- Unclear
- Microbiological picture is one of reduced or absent lactobacilli, an increase in anaerobes, mycoplasmas and Gardnerella vaginalis, and an increased vaginal pH
- **Not** currently considered to be an **STI** so treatment of male partners is not necessary

Risk of Bacterial Vaginosis is associated with multiple sexual partners, douching, IUCD and smoking.

Symptoms

- **Note:** May be asymptomatic (50%)
- Increase in amount of discharge
- Fishy odour – accentuated after sex (without a condom)

Signs

- White/greyish thin adherent discharge
- No inflammation of vagina or vulva

Complications

- Usually none
- Implicated in some cases of PID, post-abortal sepsis, sepsis after gynaecological surgery, late miscarriage, premature rupture of membranes (PROM), preterm delivery and post partum endometritis

Tests

- Laboratory diagnosis is usually made on the basis of a vaginal gram stain – this is usually reported as “**mixed bacteria present consistent with bacterial vaginosis**” or “**clue cells**”

Note: A positive culture for Gardnerella vaginalis is not diagnostic, as this is only one of a number of organisms involved and may be isolated from women without BV.

Specimen Collection

- High vaginal Transwab – lab will perform gram stain

Management

General Advice

- Avoid douching

Do treat:

- **Symptomatic women** with a vaginal gram stained slide reported as BV
- **Asymptomatic high-risk pregnant women** (pre-pregnancy weight <50kg or previous pre-term delivery) – the results of clinical trials have been conflicting. However, the available evidence suggests that treatment of these women **may** improve pregnancy outcome.
- **Asymptomatic women pre-TOP or pre-IUCD insertion:** Current acceptable practice is that asymptomatic women pre-TOP or pre-IUCD insertion should be treated to reduce the chances of post- procedure Pelvic Inflammatory Disease. The evidence to support this is limited however, and is still under review.

Don't treat:

- **Asymptomatic women** who do not fit the above criteria

Notes:

- **Asymptomatic low risk pregnant women:** There is not enough evidence to support routine treatment in order to prevent pre-term delivery and peri-partum sepsis. There is no evidence for routine screening for BV in pregnancy.

Treatment

Nitroimidazoles

- Metronidazole 400mg bd po 7 days

Note: Other nitroimidazoles in a 7 day course are probably effective for the treatment of BV but are not included in the recommended regimens due to lack of evidence.

Alternative Treatment

- Metronidazole 2G po stat (only 60% effective)
- Clindamycin 300mg bd for 7 days (note specialist recommendation required)

Note: Intravaginal clindamycin and metronidazole are not available at present in New Zealand.

Pregnancy and Breastfeeding

- Metronidazole 400mg bd po for 7 days
 - The 7 day course is preferred to avoid high peak serum levels, and to ensure eradication of organisms from the chorioamnion when treating women at high risk for pre-term birth
 - Metronidazole can affect taste of breast milk
 - Metronidazole is now licensed for use at any gestation
 - Repeat high vaginal swab 1 month after treatment if patient pregnant and high risk
- Clindamycin 300mg bd for 7 days (note specialist recommendation required)

Referral Guidelines

Referral to a Specialist Sexual Health Service is recommended for:

- Recurrent bacterial vaginosis