

BACTERIAL VAGINOSIS

March 2010

Bacterial vaginosis (BV) is common, affecting 10-40% of women of reproductive age globally. It causes an abnormal discharge and/or unpleasant odour, but up to 50% of women are asymptomatic. BV is associated with adverse pregnancy outcomes such as preterm labour, spontaneous abortion, low birth weight, and endometritis/PID following invasive gynaecological procedures such as TOP and IUCD insertion. Importantly, it is also associated with an increased risk of acquiring STIs and HIV infection.

BV is characterized by changes in the normal vaginal flora, with a reduction in hydrogen peroxide producing lactobacilli and an overgrowth of anaerobic bacteria; however, as yet no clear causative agent has been identified. Molecular methods have recently identified several promising aetiologic candidates that appear to be highly specific for BV and were not detected by previous culture-based methods (including BV associated bacterium-1 (BVAB1), BVAB2, BVAB3, Atopobium vaginae, and Megasphaera spp). These organisms appear highly specific for BV but further research is needed to determine if they are causative.

It is unclear if BV is sexually transmitted. Detection of BV in women pre-coitarche and the failure of past partner treatment trials to prevent BV recurrence has been considered as evidence against sexual transmission. However observational evidence increasingly supports sexual transmission of BV: it is most prevalent in populations with high rates of STIs, it is strongly associated with risk behaviours that characterize STIs (recent partner change, increased number of sexual partners and lack of condom use), and BV is not detected in truly sexually-inexperienced women.

Established risk factors for BV include recent change in sexual partners, lack of condom use, increased numbers of recent and lifetime sexual partners, douching and female sexual partners. BV is consistently more prevalent in women with female partners compared to heterosexual women, although the reasons for this are unclear. Published evidence supports recommending condom use and reducing unprotected sexual exposures to prevent BV.

DIAGNOSIS

BV is currently diagnosed by one of two methods.

1. The Amsel method requires 3 or more of the following criteria to be present
 - Clinician observed homogenous white adherent vaginal discharge
 - Vaginal pH of >4.5.
 - The presence of "clue cells" on a gram stain or wet prep from a high vaginal swab.
 - Positive amine test (whiff test).
2. The Nugent method grades vaginal bacterial morphotypes visible on a Gram stain
 - 0-3: normal flora
 - 4-5: intermediate flora
 - 7-10: BV

TREATMENT

Current Treatment is recommended for all symptomatic women. Asymptomatic women should be treated if undergoing invasive gynaecological procedures (such as TOP or IUD insertion).

Treatment in pregnancy is recommended for all symptomatic women. Treatment of asymptomatic women at high risk of preterm delivery has improved

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obstetric outcomes in 3 of 4 studies. Whether treatment of asymptomatic pregnant women with BV who are at low risk for preterm delivery reduces adverse outcomes of pregnancy is unclear with mixed results from studies. Treatment of male sexual partners has not been shown to reduce BV recurrence. Screening female partners and treatment of BV if it is detected is recommended.

Recommended Treatment for non-pregnant women

- Metronidazole 400mg bd for 7 days.
or
- Clindamycin cream PV nocte for 7 nights. Or Metronidazole gel 0.75% one applicatorful nightly for 5 nights (private script).

Please note Stat 2g doses of Metronidazole or Tinidazole are no longer recommended by the CDC guidelines at all as they are less effective.

Clindamycin cream is oil based and can weaken condoms. Metronidazole can cause nausea and the patient should be advised to have her medication with food and to avoid drinking any alcohol whilst on treatment.

Treatment in pregnancy:

While the optimal regimen in pregnancy has not been established many specialists recommend oral rather than topical antibiotics.

- Clindamycin 300mg bd for 7 days (category A)
OR
- Metronidazole 400mg bd for 7 days (category B2).

Intravaginal clindamycin should be avoided in the second half of pregnancy and tinidazole should be avoided in pregnancy.