Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

Bacterial vaginosis

Cause

Overview

- Most common cause of abnormal vaginal discharge in people of childbearing age
- Up to 50% of people are asymptomatic
- While BV is not currently considered to be a sexually transmitted infection (STI), there is strong observational evidence supporting the contribution of sexual transmission to its pathogenesis
- Risk factors include:
    - Sexual partner change (or sex with the same partner for recurrent BV)
    - Vaginal douching
    - Presence of an intrauterine device (IUD)
- Hormonal contraception appears to be protective regardless of type. Condom use or having a male partner who is circumcised is also protective
- Recurrence is common

Clinical presentation

Signs and symptoms
Approximately 50% of people are asymptomatic
Thin white homogenous vaginal discharge without obvious vaginal inflammation
Offensive fishy odour
Complications
Although BV may be associated with a number of adverse health outcomes, routine screening and treatment has not been conclusively shown to reduce the risk. • Spontaneous abortion, premature labour, chorioamnionitis, postpartum endometritis • Pelvic inflammatory disease (PID) • Endometritis, post termination of pregnancy or IUD insertion • Often associated with STIs including chlamydia, gonorrhoea and trichomoniasis • HIV transmission and acquisition

Indications for testing

- Vaginal discharge
- Vaginal odour

Routine screening in asymptomatic people is not recommended, however there is considerable regional variation in testing recommendations before IUD insertion or termination of pregnancy. Clinicians should follow their local guidelines in these circumstances

Recommended tests

- All people complaining of vaginal discharge should be examined to identify relevant clinical signs, and to exclude a retained foreign body (e.g. tampon or condom) as a cause of the discharge
- Self-collected swabs can be obtained if examination is declined, but this is not recommended
- Trichomoniasis, chlamydia and gonorrhoea are other possible causes of vaginal discharge. **Unless STIs have been excluded, testing should occur as part of a full sexual health check**

Test	Consideration
High vaginal swab for Candida and BV	Clinical details must be included on laboratory form to ensure sample is processed appropriately Candidiasis is another common cause of unusual vaginal discharge
Consider:	
Vulvovaginal NAAT swab for chlamydia, gonorrhoea and trichomoniasis	If examined, vaginal swab should be taken before speculum insertion Trichomoniasis, chlamydia and gonorrhoea are other possible causes of unusual vaginal discharge and should be excluded
HIV and syphilis serology	If STI screening is indicated

NAAT – Nucleic Acid Amplification Test

Management

- Treatment is predominantly aimed at alleviating symptoms and is indicated in **symptomatic** people
- The benefits of treatment are inconclusive for the following people. Refer to local protocols:
    - Asymptomatic people undergoing an invasive upper genital tract procedure e.g. termination of pregnancy or IUD insertion
    - Asymptomatic pregnant people with a history of previous pre-term delivery

Recommendation	Alternative

Metronidazole 400 mg orally with food, twice daily for 7 days	Metronidazole 2 g orally, as a single dose (less effective than 7 day course) OR Ornidazole 500 mg orally, twice daily for 5 days (avoid in pregnancy) OR Clindamycin 300 mg orally, twice daily for 7 days

Special Situations

Situation	Recommendation
Breastfeeding	• Metronidazole may affect taste of breast milk; avoid high doses in breastfeeding • Current recommended dose of metronidazole 400 mg orally, twice daily for 7 days is safe in breastfeeding
Pregnancy	• Metronidazole 400mg orally with food, twice daily for 7 days • Symptomatic pregnant people should be treated • Treatment of asymptomatic pregnant people has not been shown to improve pregnancy outcomes • Treatment of pregnant people with BV who have a history of previous pre-term delivery MAY reduce the risk of a further pre-term delivery but the evidence is inconclusive – refer to local protocols
Allergy or contraindications	• If allergic or intolerant to nitroimidazoles, use clindamycin 300 mg orally, twice daily for 7 days or seek specialist advice.

Post-menopausal women	• Menopause alters the vaginal microbiome, which affects the validity of laboratory diagnostic criteria for BV. Symptoms may be related to atrophic vaginitis. Consider the use of topical oestrogen

- If a patient has an IUD leave it in place and treat as recommended. Seek specialist advice as needed
- Single dose and short duration regimens are associated with higher rates of recurrence
- Recurrence is common. Seek specialist advice if more than 3 recurrences in a 12-month period

Partner notification and management of sexual contacts

- Contact tracing is not required
- Treatment of male partners has not been shown to be effective in reducing the risk of recurrence so is not currently recommended
- As concordance for BV is high in female partnerships, assessment and treatment of positive female partners may be reasonable, although there is no evidence that this will reduce recurrences

Follow up

Follow up
• Not required unless symptoms persist or recur
Test of cure
• Not recommended

Indications for specialist referral

Referral to or discussion with a sexual health specialist is recommended for:

- Persistent or recurrent bacterial vaginosis
- Allergy to standard treatment options

Auditable outcomes

- 100% of patients with vaginal discharge are offered examination

Useful patient resources

What's going on down there

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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