Vaginal Discharge Clinical Guidelines

Definition

Vaginitis is defined as any condition with symptoms of abnormal vaginal discharge, odor, irritation, itching, or burning. The most common causes of vaginitis are bacterial vaginosis, vulvovaginal candidiasis, and trichomoniasis.

Assessment (History and Examination)

TABLE 1

Signs and Symptoms of Vaginitis

Diagnosis	Etiology	Symptoms	Signs	Other risks
Bacterial vaginosis	Anaerobic bacteria *(Prevotella, Mobiluncus, Gardnerella vaginalis, Ureaplasma, Mycoplasma)*	Fishy odor; thin, homogenous discharge that may worsen after intercourse; pelvic discomfort may be present	No inflammation	Increased risk of HIV, gonorrhea, chlamydia, and herpes infections
Vulvovaginal candidiasis	*Candida albicans,* can have other *Candida* species	White, thick, cheesy, or curdy discharge; vulvar itching or burning; no odor	Vulvar erythema and edema	—
Trichomoniasis	*Trichomonas vaginalis*	Green or yellow, frothy discharge; foul odor; vaginal pain or soreness	Inflammation; strawberry cervix	Increased risk of HIV infection Increased risk of preterm labor Should be screened for other sexually transmitted infections
Atrophic vaginitis	Estrogen deficiency	Thin, clear discharge; vaginal dryness; dyspareunia; itching	Inflammation; thin, friable vaginal mucosa	—
Irritant/allergic vaginitis	Contact irritation or allergic reaction	Burning, soreness	Vulvar erythema	—
Inflammatory vaginitis	Possibly autoimmune	Purulent vaginal discharge, burning, dyspareunia	Vaginal atrophy and inflammation	Associated with low estrogen levels

HIV = human immunodeficiency virus.

Information from references 10, 14, and 15.

Management

TABLE 4

Treatment Regimens for the Most Common Causes of Vaginitis

Initial regimens	Alternative regimens	Pregnancy	Recurrence	Treatment of sex partners
Bacterial vaginosis				
Metronidazole (Flagyl), 500 mg orally twice daily for seven days* *or* Metronidazole 0.75% gel (Metrogel), one full applicator (5 g) intravaginally daily for five days *or* Clindamycin 2% cream, one full applicator (5 g) intravaginally at bedtime for seven days†	Tinidazole (Tindamax), 2 g orally once daily for two days *or* Tinidazole, 1 g orally once daily for five days *or* Clindamycin, 300 mg orally twice daily for seven days *or* Clindamycin (Cleocin Ovules), 100 mg intravaginally at bedtime for three days	Metronidazole, 500 mg orally twice daily for seven days	First recurrence: Retrial of same regimen *or* Trial of alternative initial regimen Multiple recurrences: Metronidazole 0.75% gel, intravaginally twice weekly for four to six months	Routine treatment of sex partners is not recommended
Vulvovaginal candidiasis				
Topical azole therapy‡ (Table 5) *or* Fluconazole (Diflucan), 150 mg orally, single dose	—	Topical azole therapy applied intravaginally for seven days	To achieve mycologic cure§: Topical azole therapy for seven to 14 days *or* Fluconazole, 150 mg orally every third day for three doses For maintenance: Oral fluconazole (100 mg, 150 mg, or 200 mg) weekly for six months; consider topical treatment if oral is not feasible	Routine treatment of sex partners is not recommended unless the partner is symptomatic
Trichomoniasis				
Metronidazole, 2 g orally, single or divided dose on the same day *or* Tinidazole, 2 g orally, single dose	Metronidazole, 500 mg orally twice daily for seven days	Metronidazole, 2 g orally, single dose in any stage of pregnancy	Differentiate persistent or recurrent infection from reinfection‖ If metronidazole, 2-g single dose fails: Trial of metronidazole, 500 mg twice daily for seven days If metronidazole, 500 mg twice daily for seven days fails: Trial of metronidazole, 2 g daily for seven days If above regimens fail: Consider susceptibility testing (contact Centers for Disease Control and Prevention)	Concurrent treatment of sex partners is recommended Advise refraining from intercourse until partners are treated and symptom-free

*—Because of disulfiram-like reaction, alcohol should be avoided for at least 24 hours after completing oral regimen.
†—Clindamycin cream is oil-based and can weaken latex condoms and diaphragms for at least five days after use.
‡—Topical azole creams and suppositories may be oil-based and can weaken latex condoms and diaphragms.
§—For *Candida albicans* infection. Consider culture to exclude nonalbicans infection. If nonalbicans infection is present, consider first-line therapy with seven to 14 days of a nonfluconazole azole agent. If infection recurs, prescribe 600 mg of boric acid in a gelatin capsule intravaginally once daily for two weeks. Boric acid may also be used with initial induction therapy followed by monthly maintenance therapy for recurrent albicans infection per the Society of Obstetricians and Gynaecologists of Canada recommendations.[16]
‖—Follow-up with retesting as early as two weeks but within three months is recommended because rates of reinfection are high.

Information from references 9 and 16.

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