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The management of women of reproductive age (3) *Vaginal Discharge*

The clinical diagnosis of the vaginal discharge in women of reproductive age was discussed in issues “48” of the “Update”. The medical treatment for common infective causes of vaginal discharge was discussed in issue “49”. In the current issue “50” the medical treatment for common infective causes of vaginal discharge in specific clinical situations (recurrent infection, partner treatment and treatment during pregnancy) is discussed

It is advisable to refer to the current edition of the British National Formulary (BNF) for dosing regimens.

	Bacterial vaginosis	Candida	Trichomoniasis
Recurrent infection	<p>Suppressive therapy <i>Oral metronidazole:</i> 400 mg twice daily for 3 days at the beginning and end of menstruation <i>Intravaginal metronidazole (0.75%):</i> 5 g applicator twice weekly for 4–6 months after an initial 10-day course (outside product licence)</p> <p>Avoid douching, and shampoo, gels and antiseptics in the bath</p>	<p>Induction regimen (as above for initial treatment)</p> <p>Maintenance regimen <i>Oral fluconazole:</i> 100 mg as a single dose weekly for 6 months <i>Clotrimazole pessary:</i> a single 500 mg pessary weekly for 6 months <i>Oral itraconazole:</i> 400 mg (two divided doses in 1 day) monthly for 6 months</p> <p>Avoid local irritants, perfumed products, tight-fitting synthetic clothing</p>	<p>Treatment failure</p> <p>Exclude vomiting with metronidazole and repeat standard regimen as above</p> <p>Check risk of re-infection, partner notification and treatment, and compliance</p> <p>If drug resistance is suspected seek specialist advice</p>
Partner treatment	Routine screening and treatment of male sexual partners not recommended	Routine screening and treatment of male sexual partners not recommended	Partner notification and treatment is recommended. Screen for other STIs
Treatment in pregnancy	Symptomatic women should be treated as above	Treatment with topical azoles as above but longer duration of treatment (7 days) may be required Avoid oral regimens due to potential teratogenicity	Meta-analyses do not indicate teratogenicity of metronidazole even in the first trimester
Special notes	Avoid alcohol with metronidazole Avoid high-dose single regimens if breastfeeding, use intravaginal treatment Clindamycin intravaginal cream can damage latex condoms	Latex condoms, diaphragms and cervical caps may be damaged by vaginal preparations containing econazole, miconazole, isoconazole or clotrimazole	Spontaneous cure rate of 20–25% Avoid alcohol with metronidazole Avoid high-dose single regimens if breastfeeding