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Bacterial Vaginosis

Bacterial vaginosis accounts for over 50% of vaginal infections in women of childbearing age. Patients usually complain of an unpleasant discharge that may be thin, colored and have a fishy smell particularly after intercourse. BV is caused by a group of anaerobic type bacteria which are normal in the vaginal flora. If there is an imbalance in the types of bacteria, symptoms of vaginitis occur. The overgrowth of certain organisms like Gardnerella vaginitis and other anaerobes produce an amine odor caused by the elevated pH. The vagina usually has large amounts of lactobacilli which produce hydrogen peroxide and maintains a balanced acidic pH.

BV is found in women of all ages, including women who are not sexually active. BV is more common with a new sexual partner, douching and cigarette smoking. The presence of BV can be associated with other infections as well and must be present in a concentration of greater than 20% to be considered an infection. Most patients with only BV do not have itching, inflammation or redness. BV can be diagnosed in the office with the finding of a thin grey-white smooth discharge that coats the walls, elevated vaginal pH, fishy odor reaction to KOH or identification of “clue cells” on the wet mount.

Cultures are not needed to diagnose BV. BV should be differentiated from: trichomonas, combined yeast infection, atrophic vaginitis and desquamative inflammatory vaginitis, all of which have more inflammation and dyspareunia. BV can spontaneously resolve in up to half of patients as the vaginal flora returns to a normal balance. Treatment of BV with metronidazole or clindamycin either orally or vaginally has a high cure rate of 70 to 80%. Oral medication is convenient but may have GI side effects. Metronidazole can be given as a 7 day or 14 day treatment. Follow-up is not needed if the symptoms resolve.

Patients who have BV but no symptoms do not need treatment. In certain situations, such as before surgery or in an immune compromised women treatment may be indicated. Treatment options include: Metronidazole gel 5 g once a day for 5 days, 500 mg of oral Flagyl twice a day for 7 days, clindamycin 5-g cream as one dose to last for 7 days, clindamycin 300 mg twice a day for 7 days or clindamycin suppositories 100 mg once a day for 3 days or tinidazole 1g a day for 5 days. Oral metronidazole can be used in any trimester of pregnancy to treat BV.

Approximately 30% of patients with HPV infection will have recurrent symptoms within 3 months. Reinfection is possible however most recurrences are caused by a lack of return of the vaginal flora to a normal pH. Patients with more than 3 recurrences per year can be given long term treatment with weekly applications for 3 to 6 months using metronidazole gel. Douching should be avoided and vaginal acidifying agents have not proven to enhance cure. Patients who are not symptomatic should not be retreated. We recommend for all women with vaginitis to follow the healthy vulvar practices patient education guidelines.

Pearl W. Yee M.D. Inc./ patient education handout: Bacterial Vaginosis July 2008 update