**Vaginitis**

* **Presentation:**

-itching, burning, irritation, erythema, dyspareunia, spotting, dysuria, change in vaginal discharge (normal is 1-4 ml/24 hours, white/transparent, mostly odorless)

* **Differential:**

-BV, candida and trichomoniasis account for 90% of cases

-less commonly: cervicitis, atrophic vaginitis, foreign body, irritants, allergens, lichen sclerosus

* **History:**

-Don’t forget to ask about abdo pain (suggests UTI or PID) and medications (antibiotics, OCPs, antifungals, HRT), sexual history (partners, protection), and hygienic practices (panty lines, spermicides, soaps/perfumes, topical drugs)

* **Physical exam:**

-should focus on the degree of vulvovaginal inflammation and characteristics of the vaginal discharge, the presence of cervical inflammation and abdominal or cervical motion tenderness

-If possible, pH, microscopy (saline wet mount, KOH mount), amine/’whiff’ test

-Swabs (vaginal + cervical culture) if diagnosis not obvious based on above tests

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Vulvovaginal Candidiasis** | **Bacterial Vaginosis** | **Trichomoniasis** |
| **Risk Factors** | DM, antibiotics, increased estrogen levels (OCP, pregnancy, HRT), immunosuppression, contraceptive devices | Sexual intercourse, women who have sex with women, new/multiple sexual partners, douching, smoking | Sexually transmitted, high rate of co-infection with other STIs (males are carriers) |
| **Symptoms and signs** | -**Pruritis**, soreness, dysuria,dyspareunia  -vulvar erythema +/- edema; white, clumpy discharge  -sxs often worse prior to menstruation | 50-75% asymptomatic  -fishy-smelling discharge (more noticeable after coitus), homogeneous thin, grey-ish white  -rarely, dysuria, dyspareunia (pruritis and inflammation typical absent) | Purulent, malodorous, thin discharge’ burning, pruritus, dysuria, frequency, dyspareunia  -sxs +/- worse during menstruation  -Vulvar/vaginal erythema, green-yellow frothey d/c in 10-30%;punctate hemorrhages on vagina and cx (strawberry cx) |
| **Special tests** | -pH 4-4.5  -Pseudohyphae on saline/KOH mount | -pH >4.5  -postive whiff-amine test  -clue cells on saline wet mount  -no role for culture! | -pH >4.5  -Motile trichomonads on wet mount  -TEST for other STIs |
| **Treatment** | -Fluconazole 150 mg PO x 1  -Intravaginal preparations (clotirimazole cream/intravaginal tablets, miconazole cream/vaginal suppository) x 3-7 d depending on dose/method  -in pregnancy, use topical  -if immune suppressed, use 2-3 doses diflucan 72 hours apart  -can add topical steroid if severely inflamed | -Treat if symptomatic (resolves spontaneously in 1/3 non-preg and ½ pregnant women)  -May reduce risk of acquiring STIs including HIV  -Flagyl 500 mg BID x 7 days  -Flagyl gel .75% 5gm PV OD x 5 days  -Clinda 2% cream 5gm PV HS x 7 days | -Avoid intercourse until after abx and asymptomatic (~7d)  -Flagyl 2 gm PO x 1  -Flagyl 500 mg PO BID x 7 d  -Treat all cases (asymptomatic and symptomatic) and their partners |

\*\*\*Note Re: trichomonas in pregnancy: treat if symptomatic (same Rx). Don’t treat if asymptomatic as study did not show a decrease in preterm labour, rather an increase with tx (unsure why). May tx after 37 weeks though to prevent transmission to neonate (can cause fever, resp probs, uti etc).

Less frequent causes of vaginitis:

* Atrophic vaginitis
  + Occurs in peri/postmenopausal women, or hypoestrogenic states
  + Dyspareunia, dryness, burning, PV bleeding (post-coital), UTI sxs
  + O/E – atrophic vaginal mucosa, thin, pale, loss of rugae
  + Rule out vulvar intraepithelial neoplasia (visible/palpable lesion)
  + Tx -topical estrogen
* Dermatitis (irritative/allergic)
  + Hx of scented items, non-breathable undergarments, douches, creams, latex, spermicide (rarely semen plasma allergy)
  + Treatment – remove offending agent
* Vestibulodynia
  + Chronic introital pain as primary symptom, at least x 3-6 mos
  + Rule out vaginitis
  + Tx – TCAs, gabapentin