Bacterial vaginosis

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1 Bacterial vaginosis is the most common cause of abnormal vaginal discharge, affecting 23%–30% of reproductive-aged people

Bacterial vaginosis is caused by a disrupted vaginal microbiome balance. Symptoms include itch, dysuria, and a thin, grey discharge with a "fishy" odour, particularly after coitus. Risk factors include smoking and unprotected intercourse, including oral sex.[1,2]

2 Bacterial vaginosis is associated with other medical risks

It increases susceptibility to sexually transmitted infections such as HIV, *Chlamydia trachomatis*, *Neisseria gonorrhoeae*, *Trichomonas vaginalis*, human papillomavirus, and herpes simplex virus.[1] Bacterial vaginosis in pregnancy increases risks of miscarriage, preterm premature rupture of membranes, preterm labour and delivery, chorioamnionitis, and postpartum infections.[3] Screening for and treatment of bacterial vaginosis is recommended in pregnant people at increased risk of preterm birth between 12 and 16 weeks, even if asymptomatic.[3] Routine screening in asymptomatic females, pregnant or not, is unnecessary.[1,2]

3 Diagnosis is usually made after a culture of vaginal discharge

Vaginosis is presumed with 3 of the following criteria: thin homogeneous discharge; vaginal pH higher than 4.5; positive "whiff test" (a "fishy" odour after application of 10% potassium hydroxide solution to the discharge); and vaginal discharge microscopy showing clue cells (vaginal epithelial cells covered in gram-negative bacteria).[3]

4 First-line treatment regimens have comparable cure rates of 70%–80%

Topical treatment options include metronidazole gel 0.75% (5 g/applicator) once per day for 5 days, or clindamycin cream 2% (5 g/applicator) at bedtime for 7 days. Another treatment option is oral metronidazole 500 mg twice daily for 7 days. Avoiding alcohol consumption during treatment is no longer recommended.[1,4]

5 Recurrence rates at 6 months after treatment are higher than 50%

Partner treatments have not proven to be preventive. Recommendations for prevention of recurrence based on expert opinion (low level of evidence) include a trial of alternating vaginal and oral treatments; boric acid (contraindicated in pregnancy) 600 mg vaginal capsules nightly for 21 days after antibiotics; vaginal metronidazole gel twice weekly; or intrauterine device removal.[1,4,5]

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