Management of Persistent Vaginitis

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Question 1:

On average, how quickly does a yeast culture with speciation yield results? Knowing that a negative culture may take weeks before it is final, do you recommend treating the patient prior to getting the culture results back in order to control symptoms and improve quality of life outcomes?

Response from Dr. Nyirjesy:

Since the results of a yeast culture are not immediate, empirical treatment, even when microscopy is negative, may be indicated at times. I will treat patients empirically when they have moderate-to-severe symptoms or findings and are uncomfortable enough that they can’t wait for the culture result. Another situation when I might treat is if a patient has had similar symptoms in the past and had a well-documented yeast infection at the time that responded to antifungal therapy. In general, with empirical treatment, I use short courses (one or two doses) of fluconazole.

Question 2:

Regarding fistulas as a source for discharge, are small and inconspicuous rectovaginal fistulas a source of discharge or recurrent and chronic infections? If so, what is the best way to diagnosis this?

Response from Dr. Nyirjesy:

There is no clear evidence that small and inconspicuous rectovaginal fistulas are a source of recurrent or chronic vaginal infections. Furthermore, I have seen many patients undergo extensive work-ups for fistulas when a vaginal bacterial culture came up repeatedly positive for coliform bacteria such as Escherichia coli. However, since such organisms can be found as part of normal vaginal flora, finding them on a vaginal culture is not a reason to do a fistula work-up.

Rectovaginal fistulas may be an occasional cause of an abnormal discharge. I will usually consider a work-up if the discharge has an appearance consistent with small or large bowel secretions, especially if the
Question 3:

At what point in the evaluation of physiologic discharge do you order imaging studies to rule out fallopian tube malignancy? Do you order imaging on all patients prior to a final diagnosis of physiologic discharge?

Response from Dr. Nyirjesy:

I do not routinely order imaging studies on patients with a physiologic discharge, since I feel that the discharge is in most cases coming from the cervix and vagina, and that patients have been sensitized to look for a discharge and consider it abnormal due to previous overdiagnosis of infection. I will consider imaging for fallopian tube cancer in situations where patients have other symptoms of concern, such as pelvic pain or pressure or a palpable lump.

Question 4:

Although you cite evidence for increased rates of recurrent vulvovaginal candidiasis and bacterial vaginosis, you recommend against treating the sexual partners. Is there a role for preventative treatment of the patient prior to or after sexual activity?

Response from Dr. Nyirjesy:

To my knowledge, there are no studies of the possible use of preventive treatment for either vulvovaginal candidiasis or bacterial vaginosis around the time of sexual activity. I have not tried this in my own practice for either condition. If such a treatment were attempted, I am not aware of any recommendations about which drug to use, when to take it, and for how long.

Question 5:

Is there evidence to support the use of oral or vaginal probiotics for management of recurrent vulvovaginal candidiasis?

Response from Dr. Nyirjesy:

Although probiotics are commonly used by women who have recurrent vulvovaginal candidiasis, there is no good evidence to support their use. To date, the presence of vaginal lactobacilli does not seem to protect against vulvovaginal candidiasis (see J Infect Dis 1996;174:1058–63). Furthermore, in a well-done, randomized double-blind placebo-controlled Australian study, oral probiotics did not decrease the risk of getting vulvovaginal candidiasis after a course of antibiotics (see BMJ 2004;329:548). In general, I discourage patients from using probiotics for vaginal infections as I feel they are an ineffective and costly intervention.

Question 6:

In your practice, do you routinely treat the patient’s sexual partner for trichomoniasis or do you have them evaluated and treated by their own physician? If you treat the partner, do you bring him or her in for an office visit and medical history prior to treatment, or do you use expedited partner therapy?
Response from Dr. Nyirjesy:

*If the partner is present for the office visit when trichomoniasis is diagnosed, I will provide treatment after obtaining a problem-focused medical history. Now that it is legal in the state of Pennsylvania, we also use expedited partner therapy as reinfection rates may be lower with this approach (see Sex Transm Dis 2010;37:392–6). However, this approach is not legal in certain states, and providers should be aware of their local laws about expedited partner therapy.*

In women with metronidazole-resistant trichomoniasis, what constitutes optimal treatment of the partner is unclear. I will ask the patient to bring her partner in whenever possible so that I can discuss the treatment plan with him.

**Question 7:**

Is there any role of vaginal estrogen therapy in recurrent bacterial vaginosis in certain age groups (eg, perimenopause) in helping to speed healing of the vaginal mucosa and decrease vaginal irritation?

Response from Dr. Nyirjesy:

*We do not use estrogen therapy to prevent recurrent bacterial vaginosis, although we will use it in the occasional perimenopausal or menopausal woman who has bacterial vaginosis and, as a separate issue, atrophic vaginitis.*

**Question 8:**

In your discussions with patients with atrophic vaginitis, what do you tell them to expect for duration of treatment with vaginal or oral estrogens? How do you counsel a successfully treated woman who wants to continue estrogen treatment indefinitely?

Response from Dr. Nyirjesy:

*Because of ongoing safety concerns and resistance by patients to taking oral estrogens, I tend to use mostly vaginal estrogens. When I initiate therapy, I emphasize that they may be relatively slow to work and that patients should use them for a minimum of 3 months to see how much benefit they will get from estrogen. With topical therapy, I warn them that the most common side effect will be local burning, irritation, or itching from the medication itself (the most common side effect of ANY topical); but, it will usually go away on its own. For successfully treated patients, I try to wean them down to the lowest dose that keeps the symptoms controlled.*

*In general, I defer to the guidelines from the North American Menopause Society (see Menopause 2013;20:888–902). Although they stress that there are little to no data about the safety of long-term use of vaginal estrogens, they also do not point to any clear evidence that long-term use is inappropriate. For patients on long-term vaginal estrogen, I discuss the lack of available data about long-term use. In my experience, most patients are so happy to feel comfortable again that they are willing to deal with the uncertainties about long-term use.*
Question 9:

Some women undergoing breast cancer treatment with aromatase inhibitors will have severe symptoms of vulvovaginal atrophy. Is current treatment of breast cancer an absolute contraindication to the use of vaginal estrogen for management of vulvovaginal atrophy?

Response from Dr. Nyirjesy:

As noted in the North American Menopause Society guidelines (see Menopause 2013;20:888–902), even vaginal estrogen may increase serum estradiol levels in women on aromatase inhibitors. Less clear is whether these changes affect the risk of recurrence of or mortality from breast cancer. As recommended by these guidelines, I ask breast cancer survivors with atrophic vaginitis to discuss the risks and benefits of low-dose vaginal estrogen therapy with their oncologists. In my experience, most oncologists have not considered breast cancer an absolute contraindication to the use of vaginal estrogen, particularly when the patient is suffering from severe vaginal symptoms that are unrelieved by non-hormonal approaches.