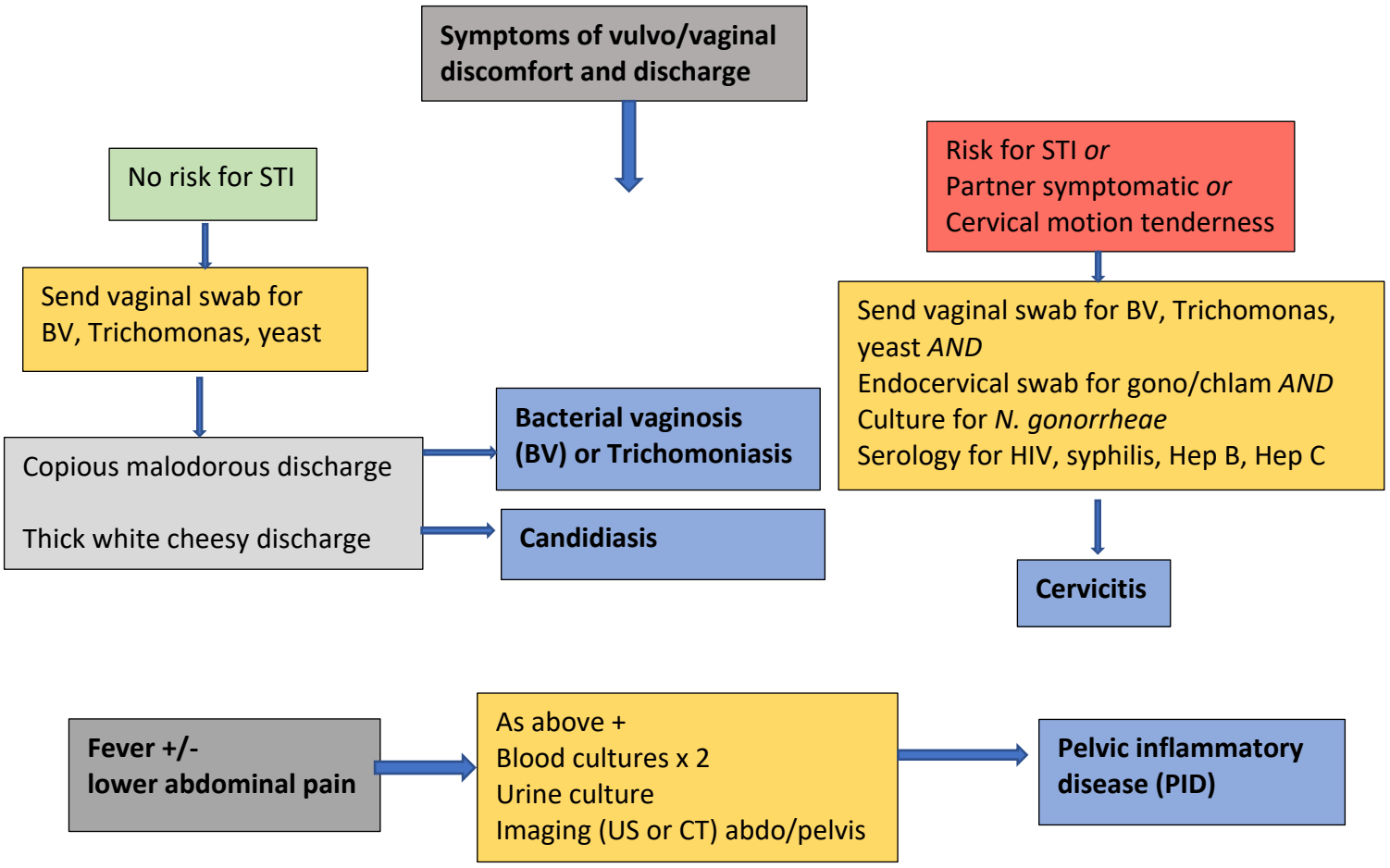
Vulvovaginitis, Cervicitis and Pelvic Inflammatory Disease (PID)

Infections involving the vulva and vagina are often characterized by non-specific symptoms such as vaginal discomfort, pruritus and discharge. Infections affecting the cervix can progress to the endometrium, fallopian tubes and other pelvic structures causing pelvic inflammatory disease (PID), which often manifests with fever and lower abdominal pain. The goals of therapy are symptom relief, prevention of progression to peritonitis/pelvic abscess, prevention of long-term sequelae such as infertility, ectopic pregnancy and chronic pelvic pain.

Symptoms tend to be non-specific and difficult to differentiate from non-infectious conditions. **Definite diagnosis is based on a combination of clinical assessment (including external genital examination, speculum examination for cervical motion tenderness) and laboratory testing**. Empiric therapy can be initiated pending results of testing, particularly when cervicitis is suspected. Failure to responding to standard therapy should prompt consideration of alternative diagnoses, namely non-infectious syndromes.

The following approach can be used to guide management:



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VULVOVAGINAL CANDIDIASIS *Candida albicans;* other *Candida sp* less common Risk factors: recent antibiotic use, pregnancy, steroids, diabetes, immunocompromise	**Uncomplicated disease, immunocompetent patient:** Topical antifungal (e.g. clotrimazole 1% cream) x 3-7 days *OR* Fluconazole 150 mg PO x 1 dose **Immunocompromised or severe manifestations:** Fluconazole 150 mg PO q72h x 3 doses **Pregnant:** Topical antifungal (e.g. clotrimazole 1% cream) x 1-2 weeks **Recurrent (> 4 episodes/year) or failure of therapy: Refer to ID**
BACTERIAL VAGINOSIS[1] *(*overgrowth *of G. vaginalis, M. hominis, Prevotella sp, A. vaginae)*	Metronidazole 500 mg PO BID x 7 days [*Treat sexual partner only if balanitis*]
TRICHOMONIASIS *Trichomonas vaginalis* [STI]	Metronidazole 500 mg PO BID x 7 days [*Treat sexual partner exposed in last 60 days*]
CERVICITIS *Chlamydia trachomatis* and *Neisseria gonorrhoeae* in 25% of cases *Screening + for N. gonorrhoeae* Screening + for *Chlamydia*	Ceftriaxone[3] 250 mg IM/IV x 1 dose ***AND*** Doxycycline[2] 100 mg PO BID x 7 d [OR Azithromycin 1 g PO x 1 if pregnant] ***If severe β-lactam allergy:*** Gentamicin 240 mg IM/IV x 1 dose AND Azithromycin 2 g PO x 1 dose Ceftriaxone[3] 250 mg IM x 1 dose Doxycycline[2] 100 mg PO BID x 7 d [*OR* Azithromycin 1 g PO x 1 if pregnant] ****Treat sexual partner****
PELVIC INFLAMMATORY DISEASE (PID) Polymicrobial (*N. gonorrhea, C. trachomatis, Enterobacteriaceae, Streptococcus sp, M. genitalium, M. hominis, G. vaginalis*)	**If hemodynamically stable and tolerating PO:** Ceftriaxone[3] 250 mg IM/IV x 1 dose ***AND*** Doxycycline[2] 100 mg PO BID x 14 d [If recent instrumentation, add Metronidazole 500 mg PO BID x 14 days] **If hemodynamically unstable/not tolerating PO:** Ceftriaxone 2 g IV q24h *AND* Metronidazole 500 mg IV q8h ***AND*** Doxycycline 100 mg PT BID ***If severe β-lactam allergy:*** Clindamycin 900 mg IV q8h + Gentamicin 3-5 mg/kg IV q24h

[1]BV in pregnancy associated with premature labor, and should be treated. Screening for BV not recommended if asymptomatic, unless history of prior pre-term delivery. Metronidazole considered safe in pregnancy.
[2]Avoid doxycycline in pregnancy.
[3]If weight ≥ 150 kg, give ceftriaxone 1 g IM/IV x 1 dose

REFERENCES

Health Canada Guidelines on Sexually Transmitted infections. Accessed November 24, 2020.
IDSA - Clinical practice guideline for the management of candidiasis: 2016 update *Clin Infect Dis.* 2016:62(4)

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