



# Guideline for the management of vaginal discharge in Integrated Sexual Health Services

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## AUTHORSHIP, RESPONSIBILITY AND REVIEW

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# BACKGROUND

## **Guideline Definition**

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

## **Purpose and scope**

This guideline aims to standardise the care people receive when presenting with uncomplicated vaginal discharge in integrated sexual health (ISH) services. Management of associated abdominal pain, bleeding problems, ulcers/lesions or recurrent vaginal discharge is beyond the scope of this guideline.

## **Roles and Responsibilities**

In seeking further advice on any uncertainties contained in this document, or if you feel that there is new or more updated advice it is your responsibility to contact the guideline author or Approval Group manager so that any amendments can be made.

The guideline Approval Group is responsible for disseminating this guideline to all appropriate staff.

The guideline author or a named alternative is responsible for updating the guideline with any amendments that they become aware of or are highlighted to them.

All health professionals are responsible to ensure that the guideline is utilised effectively, and to ensure that they are competent and compassionate in the implementation of it.

## **Training Requirements**

There is no mandatory training associated with this guideline. However, it is recommended that all clinical staff working in specialised integrated sexual health services are familiar and up to date with BASHH and FSRH guidelines<sup>1,2</sup>.

## **Monitoring of Compliance**

- By audit and review of management of vaginal discharge.
- The Governance Department will collate any complaints and distribute to the relevant individuals for comments, and share any learning points.
- The Service Lead will oversee any governance issues, make relevant recommendations to the directorate, and advise the Clinical Director or the directorate of any matters that require implementation.
- The Health Board reserves the right, without notice, to amend any monitoring requirements in order to meet any statutory obligations or the needs of the organisation

## **Complaints**

All complaints should try to be resolved with the patient during any contact to avoid escalation. Their concerns should be listened to and documented. If it is not possible to address any concerns at the time, or if the complaint is of a serious nature, the patient's complaint should be discussed with the consultant in charge for the day, or the patient should be given details of how to raise a formal complaint via the local governance department.

## INTRODUCTION

Vaginal discharge is a common presenting complaint in integrated sexual health services (ISH) This can be due to non-infectious or infectious causes. The most common cause of vaginal discharge is bacterial vaginosis (BV) followed by candida (thrush). The most common sexually transmitted infection (STI) causing vaginal discharge is chlamydia, followed by gonorrhoea. Trichomonas vaginalis (TV) is the most common cause worldwide. Less common causes of vaginal discharge such as cervical herpes and retained foreign bodies are beyond the scope of this guideline.

Vaginal discharge can be distressing for the patient regardless of whether it is due to an infectious cause. Although it can be tempting to just “see and treat” the role of a specialist clinic is to appropriately diagnose and provide the patient with education and information about their condition.

Non-infectious causes of vaginal discharge rarely cause complications or consequences. Undiagnosed STIs however can lead to significant consequences such as pelvic inflammatory disease (PID), an increased risk of ectopic pregnancy and infertility, highlighting the importance of conducting a thorough assessment.

### Triage

Health care professionals triaging patients with vaginal discharge should ask if there is *new and associated* pelvic pain with the discharge – these patients should be seen by a doctor to assess for PID and other causes. Isolated vaginal discharge should be seen by nurses.

If the patient thinks they have thrush or BV (i.e., due to previous or typical symptoms) it is reasonable to recommend they access over the counter (OTC) treatment from the pharmacist and if the symptoms persist after 2 weeks, they can call us back. All patients should be given an appointment if they want to be seen.

## IN-CLINIC ASSESSMENT

### History taking

All patients should have a thorough history taken as per BASHH guidelines<sup>3</sup> and aided by the proforma on the ISH electronic patient record system ‘Lilie.’

In particular, the following aspects should be asked:

- Timescale of symptoms
- Character of vaginal discharge (colour, consistency, amount, smell)
- If it has happened before and how it was treated
- If any OTC treatments have been used for this episode
- Any associated symptoms such as pelvic pain, urinary symptoms, bleeding after sex or between periods
- Smear test history if eligible
- Contraception and last menstrual period (LMP)
- General medical history

A sexual history and assessment of STI risk should always be done and the window period of the last test should be noted.

### Examination

All patients should be offered a speculum examination with a chaperone

If over-due, opportunistic smear tests should be offered

Vulvo-vaginal swabs (VVS) for chlamydia and gonorrhoea (yellow top) should be done prior to gel and speculum insertion, to avoid inhibitory results

The vulva and vaginal should be noted for any abnormalities

The character of any vaginal discharge should be noted

The cervix should be visualised fully and any cervicitis or bleeding should be noted

The following samples should be taken:

- VVS NAAT prior to speculum
- pH strip of vaginal discharge
- High vaginal swab (HVS) from vaginal wall and posterior fornix for candida, BV and TV (charcoal black top)
- Vaginal wall wet and dry slide (omit if microscopy not available)
- Consider a second vaginal NAAT swab for Mycoplasma Genitalium (MGen) if
  - Contact of MGen
  - Post coital bleeding with mucopurulent discharge or
  - Suspect PID
- Endocervical charcoal swab for GC culture only if you intend to give treatment on the day
  - For GC contact
  - Frank mucopurulent discharge

If a patient declines an internal examination, they can do self-taken VVS and HVS and await the results, but clinicians should explain that HVS may not be as accurate

The examination should be abandoned if painful or distressing for the patient

If a speculum examination is being performed for another reason (e.g., contraceptive procedure or smear test) and the patient does not complain of vaginal discharge, swabs should not be taken to look for BV or candida as asymptomatic treatment in non-pregnant women is not recommended.

If a patient has multiple urinary symptoms such as dysuria, frequency, urgency, suprapubic tenderness or blood in the urine, perform a urine dipstick on a mid-stream urine sample. See appendix 1 for urinalysis protocol and diagnosis of possible urinary tract infection (UTI).

## **Microscopy**

All specialist ISH services should have access to microscopy to aid accurate diagnosis and avoid unnecessary empirical treatment. Staff using microscopy or preparing slides should be appropriately trained. Wet slides should ideally be examined within 10 minutes so any trichomonads do not lose motility

## **Diagnosis**

Ectropion's are very common in young people and do not indicate cervicitis or infection. pH can be increased by other things such as semen, menstruation, low oestrogen or recent antibiotics so is not reliable on its own to diagnose BV.

Non-gonococcal urethritis (NGU) is a diagnosis in men and people with male anatomy only

Appendix 2 shows a table of typical clinical features found in different causes of vaginal discharge. However, it should be noted that these are *typical* signs and not present in all patients. Some diagnostic criteria to aid diagnosis and guide when to give treatment is given below:

## Bacterial vaginosis

- Hay/Ison criteria grade 3 on microscopy
  - Grade 0: no bacteria seen, epithelial cells only
  - Grade 1 (Normal): Lactobacillus morphotypes predominate
  - Grade 2 (Intermediate): Mixed flora with some Lactobacilli present, but Gardnerella or Mobiluncus morphotypes also present – *consider treatment if typical clinical features*
  - Grade 3 (BV): Predominantly Gardnerella and/or Mobiluncus morphotypes. Few or absent Lactobacilli
  - Grade 4 Gram positive cocci predominate (consider aerobic vaginitis)
- Amsel criteria 3 out of 4 met
  - Typical thin homogenous discharge
  - Vaginal pH > 4.5
  - Amine odour after adding 10% KOH (whiff test)
  - Clue cells on microscopy on wet mount
- In the absence of microscopy, it may be reasonable to treat BV if all three are present:
  - Typical thin homogenous discharge
  - Distinct “fish-like” odour
  - Vaginal pH > 4.5

## Vulvo-vaginal candida

- Typical symptoms with associated signs
  - i.e., itching and soreness with thick curd-like discharge, vulva excoriations/fissures/erythema
- Pseudo-hyphae or spores seen on microscopy.

## Trichomonas Vaginalis

- Typical symptoms with associated signs
  - Vulvitis and frothy yellow discharge with/without cervicitis
- Trichomonads seen on microscopy.

## Gonorrhoea

- Copious frank mucopurulent discharge
- Contact of GC

## Chlamydia

- Contact of Chlamydia

# Management

## General

If the above criteria are not met, patients should be advised to wait for results of their tests and to avoid sexual activity until then. The process of receiving results should be made clear to patients.

Give advice on vulval care:

- Avoid douching or over-washing (once daily is plenty)
- Avoid soaps, cleansing wipes, fragranced moisturisers – water is enough
- An OTC emollient (such as Hydromol) can be used as a soap substitute or emollient if there is irritation
- If irritation occurs wear white/pale cotton underwear and loose-fitting clothing
- Avoid any identified irritants

Offer condoms and advice on safe-sex

Offer full STI screen and discuss repeat testing at end of window periods (EOWP) if at risk

- NAAT for extra-genital sites if indicated by history
- HIV/syphilis bloods
- Hepatitis bloods if high risk

Assess need for contraception or emergency contraception (EC)

## Treatment of vaginal discharge

If the cause of vaginal discharge is identified from the criteria above, treatment should be given on the day for the condition as per BASHH guidelines.<sup>1</sup>

If the cause of the vaginal discharge has been identified by microscopy (i.e., BV, candida or TV) it is reasonable to discard the HVS, but still send other swabs for an STI screen.

If an infection is identified on swab results that was not treated on the day, patients should be called and offered treatment as per BASHH guidelines<sup>1</sup>

Appendix 3 gives a brief overview of standard management of BV, candida, chlamydia, GC and TV.

If you are giving treatment for a particular condition, patients should be informed the following:

- What the condition is
- Where to find out more information (e.g., sexual health Wales/sexwise)
- Whether it is sexually transmitted
- How to take the treatment, side effects, any interactions
- If they need to avoid sex or notify partners
- Whether they need a test of cure

See appendix 4 for a flowchart of overall management of vaginal discharge

## References

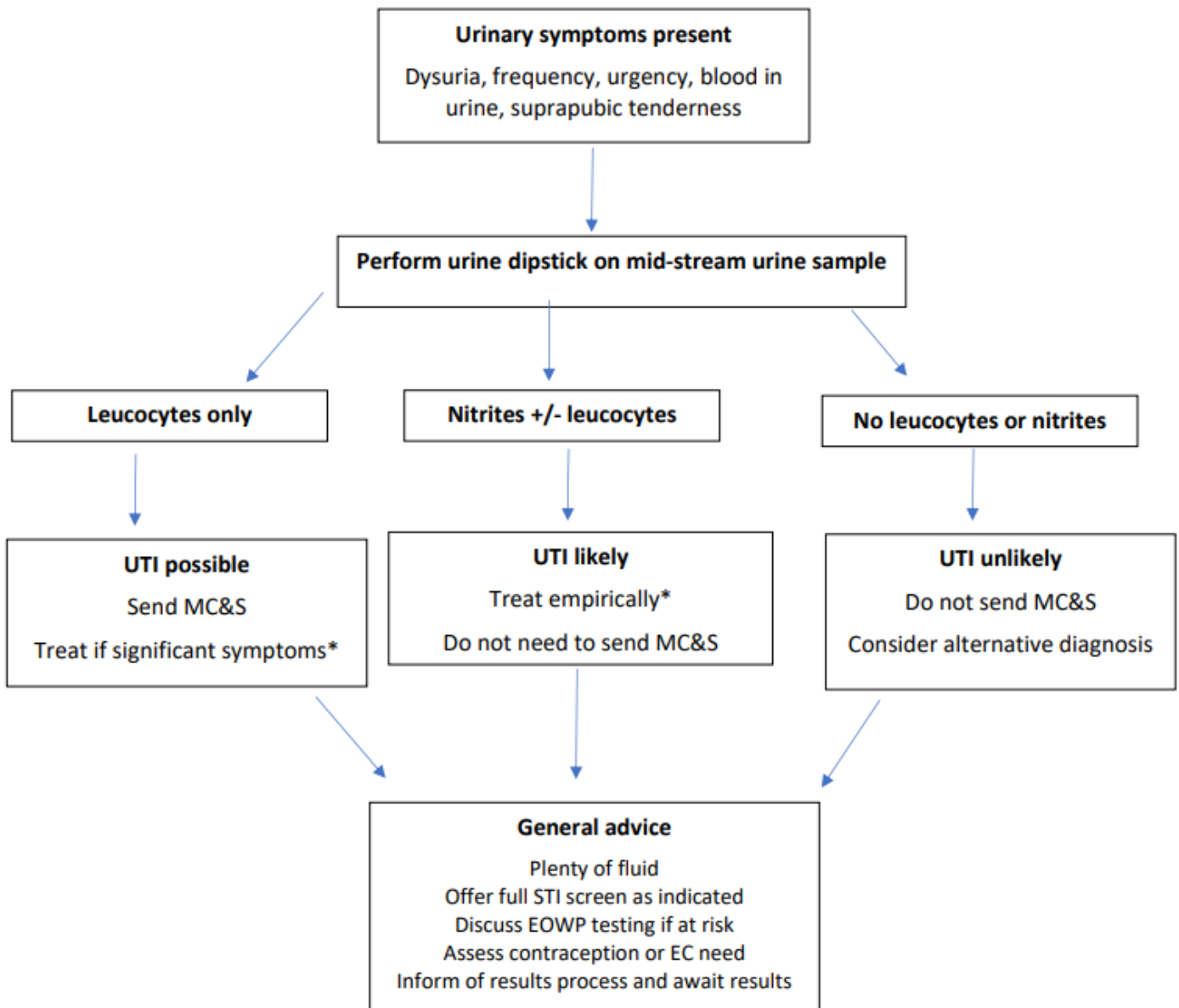
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2. <https://www.fsrh.org/standards-and-guidance/fsrh-guidelines-and-statements/>
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## List of abbreviations

BASHH	British Association for Sexual Health and HIV
BV	Bacterial vaginosis
EC	Emergency contraception
EOWP	End of window period
GC	Gonorrhoea
HIV	Human immune-deficiency virus
HVS	High vaginal swab
ISH	Integrated sexual health
LMP	Last menstrual period
MC&S	Microscopy, culture and sensitivities
MGen	Mycoplasma Genitalium
NAAT	Nucleic-acid amplification test
NGU	Non-gonococcal urethritis
OTC	Over the counter
PID	Pelvic Inflammatory disease
STI	Sexually transmitted infection
TV	Trichomonas vaginalis
UTI	Urinary Tract Infection
VVS	Vulvo-vaginal swab

## Appendix

### Appendix 1 – flowchart: urinalysis protocol



\*First line treatment

- Trimethoprim 200mg twice a day for 3 days or
- Nitrofurantoin 100mg modified-release twice a day for 3 days

## Appendix 2 – table: clinical features of vaginal discharge

Condition	Candida	BV	TV	Chlamydia	Gonorrhoea
<b>Typical symptoms</b>	Cottage-cheese/clumpy discharge, vulval itching/soreness or swelling, external dysuria, superficial dyspareunia, no odour	Fishy-smelling white-grey discharge, no associated itching/soreness or irritation	Odorous yellow discharge, associated with itching, dysuria and soreness	80% asymptomatic  Increased yellow discharge, post-coital or inter-menstrual bleeding, dysuria, pelvic pain, deep dyspareunia	50% asymptomatic  Profuse yellow-green discharge, post-coital or inter-menstrual bleeding, dysuria, pelvic pain, deep dyspareunia
<b>Typical examination findings</b>	White curdy discharge, vaginal inflammation – erythema, fissuring, swelling, associated vulval inflammation	White-grey homogenous discharge coating vaginal walls +/- odour, no associated inflammation	Profuse frothy homogenous discharge with associated inflammation or cervicitis (strawberry cervix only seen in 2%)	Normal  Increase thick yellow discharge, associated cervicitis (including contact bleeding)	Normal  Profuse thick yellow-green discharge, associated cervicitis (including contact bleeding)
<b>vaginal wall pH</b>	<=4.5	>4.5	>4.5	<=4.5	<=4.5
<b>Swab</b>	High vaginal swab from discharge or lateral vaginal wall	High vaginal swab from discharge or lateral vaginal wall	If available, NAAT swab from discharge or posterior fornix	Vulvo-vaginal NAAT	Vulvo-vaginal NAAT  Endocervical culture if suspect
<b>Typical microscopy findings</b>	Pseudo-hyphae and blastospores on gram stain	Reduced or absent lactobacilli on gram stain  Clue cells on wet mount	Flagellated motile trichomonads on wet mount	Not applicable*	Not applicable**
<b>Indications for treatment</b>	Typical clinical features  Microscopy findings	Typical clinical features with raised pH  Hay/Iison grade 3 3 out of 4 Amsel criteria	Typical clinical features  Microscopy findings	Contact of chlamydia within last 2 weeks	Typical clinical features  Contact of GC within last 2 weeks

\* The presence of endocervical or vaginal pus cells is non-specific and does not aid in diagnosis of infection, however their absence has 95% negative predictive value for PID<sup>4</sup>

\*\*gram stain has poor sensitivity in detecting gonorrhoea in females so not recommended

### Appendix 3 – table: management of common causes of vaginal discharge

For more complicated cases, including allergies, intolerances, recurrent episodes, resistance and pregnancy please refer to BASHH guidelines<sup>1</sup>

Condition	1 <sup>st</sup> line treatment	Need to abstain	Partner notification	Partner management	Test of cure**
<b>Candida</b>	Fluconazole 150mg oral stat <u>or</u> clotrimazole 500mg pessary stat	Not applicable	Not applicable	Not applicable	Not applicable
<b>BV</b>	Metronidazole 400mg oral bd 7 days <u>or</u> 2g oral stat	Not applicable	Not applicable	Not applicable	Not applicable
<b>TV</b>	Metronidazole 400mg oral bd 7 days <u>or</u> 2g oral stat	7 days after <u>both</u> partners treated	4 weeks previously	Treat male partners as testing not readily available*	Only if symptoms do not resolve – 4 weeks
<b>Chlamydia</b>	Doxycycline 100mg bd oral 7 days <u>or</u> Azithromycin 1g stat then 500mg od for 2 days	7 days after <u>both</u> partners treated	6 months previously	If sexual contact with index case within last 2 weeks offer testing and treatment  If last sexual contact over 2 weeks ago, test and await results	Only in pregnancy – 6 weeks
<b>Gonorrhoea</b>	Ceftriaxone 1g stat IM  (If result positive for GC and not treated at time, patient should have culture taken before treatment)	7 days after <u>both</u> partners treated	3 months previously	If sexual contact with index case within last 2 weeks offer testing and treatment  If last sexual contact over 2 weeks ago, test and await results	2-3 weeks***

*\*If male partners of TV found to have non-gonococcal urethritis (NGU), reasonable to treat as TV first then NGU if no improvement*

*\*\*test of cures should not be done earlier than specified time as results may be positive from persistent DNA*

\*\*\* test of cure for gonorrhoea should be emphasized if persistent symptoms, pharyngeal infection, non-first line treatment, infection acquired from South-Asia pacific

#### Appendix 4 – flowchart: vaginal discharge management

