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Optimizing Vulvovaginitis Care: A Look at Screening Modalities & Treatment Guidelines

Announcer:
You're listening to *Clinician's Roundtable* on ReachMD, and this episode is sponsored by Cepheid. Here's your host, Dr. Charles Turck.

Dr. Turck:
Welcome to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and joining me to discuss how we can optimize the detection of vulvovaginitis is Dr. Tosin Goje, who's an Associate Professor of Obstetrics and Gynecology and Reproductive Biology at the Cleveland Clinic's Lerner College of Medicine at Case Western Reserve University. She is also a board-certified OB/GYN and Reproductive Infectious Disease Specialist with the Cleveland Clinic's Obstetrics, Gynecology, and Women's Health Institute in Cleveland, Ohio. Dr. Goje, thanks for being here today.

Dr. Goje:
Thank you for having me.

Dr. Turck:
So to get us started, Dr. Goje, how do we currently diagnose vulvovaginitis?

Dr. Goje:
Currently, there are many ways vulvovaginitis is diagnosed. Some offices will use molecular testing, whether it's the NAAT—the nucleic acid amplification test—or the PCR—the polymerase chain reaction—test. Or some people use microscopy, whereby they still use saline and 10 percent potassium hydroxide to look for yeast or BV under the microscope.

Dr. Turck:
Now would you tell us about how an inaccurate diagnosis can impact patients and their overall quality of life?

Dr. Goje:
So let's start with microscopy. Microscopy is good if it's available, but it's dependent on the clinician's ability to use it. It's also dependent on the clinician's office having microscopy and being cleared or certified to use it. Many times for trichomoniasis diagnosis, if it's not performed correctly, microscopy will detect trichomonas vaginalis maybe 40 to 50 percent of the time. So you have underdiagnosis in that case. Also in patients with yeast infection that are poorly treated, with microscopy, you might not see the fungal elements because treatment was under way. And that might also lead to misdiagnosis or underdiagnosis. So some of this mode of diagnosis might delay the correct diagnosis of the patient.

It leads to a lot of frustration with the patient who will tell you, 'I know my body, I know something is not right.' And it impacts their family life, sexual life, and even work-life balance because they might have to seek help from another provider or even self-help from over-the-counter medications.

Dr. Turck:
So taking a look again at some of the screening modalities that are available, like PCR, would you share some of their pros and cons?

Dr. Goje:
PCRs are very sensitive. So for example, the NAAT test is the standard for diagnosis of trichomoniasis right now, and it's because we know that cultures and microscopy are like 40 to 50 percent or sometimes 60 percent accurate because it depends on so many other people conducting the test.

For bacterial vaginosis, the microscopy will be the most available modality to test a patient because you can look for clue cells under the microscope and check the pH. However, in my clinical opinion, I've seen that not every provider has that microscopy or the certification. So patients are just diagnosed clinically, and some diagnoses might be missed.

And the same thing with yeast infection. Although a fungal culture or fungal screen is the gold standard in diagnosis of yeast infection or vulvovaginal candidiasis, it takes on an average 7 to 12 days from what I've seen all over the country for a yeast screen or a yeast culture for the result to be finalized, and that is 7 days of a patient being uncomfortable. The PCR tests are more available, although they may be a bit more expensive, but they are readily available in most centers. They are sensitive and specific, often 90 percent, and they also have a quick turnaround time. So most places that have the PCR or any form of molecular testing for yeast should be able to have the results in 2 days, compared to maybe 7 days of a fungal screen.

Dr. Turck:
For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Tosin Goje about screening strategies for vulvovaginitis.

So Dr. Goje, what steps can we take to optimize screening and improve early detection for patients with vulvovaginitis?

Dr. Goje:
I think the number one step we should take is to improve the availability of the molecular tests in our doctor's office. It's going to, number one, improve the accuracy of diagnosis. There'll be a quick turnaround time for the patient. That way you're able to prescribe the correct antibiotic for the patient. And I think that will also help with patient satisfaction and improvement of their health status in general.

Dr. Turck:
And once a patient has been diagnosed, how do we select the best treatment option for them?

Dr. Goje:
The CDC guidelines, which is also endorsed by the American College of Obstetricians and Gynecologists, already has some guidelines for vulvovaginitis. And for vulvovaginitis, I'm talking about the common infections: vaginitis, yeast infection, bacterial vaginosis, and trichomoniasis.

For trichomoniasis, the first regimen that is approved is metronidazole. Metronidazole should be given as an oral pill 500 milligrams twice a day for 7 days. And if a patient has an allergic reaction to that class of imidazole, then they can be referred to a specialist.

For yeast infection, the first line of drug for simple yeast infection, meaning this patient has no other comorbidity like diabetes, prolonged steroid use, or immunosuppressive state, primarily we use either a vaginal insert or an oral medication. A vaginal insert could be any of the azoles that is available vaginally, or it could be an oral azole, like fluconazole. Now for patients that are classified as complicated or recurrent yeast vaginitis, we tend to have a prolonged treatment regimen for those patients. So if we're using an azole, we will use like a fluconazole 150 milligrams every 3 days times 3 doses. And if patients are resistant to the azole based on the fungal screen, which is a gold standard, or they're allergic to an azole, then you can try a non-azole. One of the non-azoles that is available right now is ibrexafungerp. There are other non-azoles that will need to be compounded as a vaginal inserts like a nystatin vaginal insert. So that is how we go step-wise in managing yeast infection.

And for bacterial vaginosis, the first line of treatments are still the metronidazole, whether it's an oral or a vaginal insert, and the second line is the clindamycin, which could be an oral or vaginal insert depending on the patient's preference, intolerance to metronidazole, or allergic reaction to metronidazole.

Dr. Turck:
Now you'd mentioned earlier referring patients to a specialist in cases where there's a trichomoniasis infection that's resistant to metronidazole. I was wondering what the patient's journey looks like clinically after they land in the specialist's office.

Dr. Goje:
Excellent question. In my practice, there are two groups of patients. For patients who have a metronidazole allergy, you refer those patients to an allergy immunologist to see if they can be desensitized and still use metronidazole or another imidazole like tinidazole. However, if it's resistant, then the specialist can discuss alternative medications for this patient. High-dose tinidazole in patients that are sensitive to tinidazole is recommended. High-dose tinidazole involves using 1 to 2 grams daily for 7 to 10 days.

Another option for patients who have a resistance and at the same time are allergic to the metronidazole group of medication is to compound a medication. Compounded paromomycin can be made and used as a vaginal cream for 2 to 3 weeks for patients. I need to note here that compounded paromomycin can be irritating to the skin, and patients should use a petroleum jelly base on their vaginal or vulva area before inserting the cream into the vagina.

Dr. Turck:
Now before we close, Dr. Goje, do you have any final thoughts you'd like to share with our audience?

Dr. Goje:
Absolutely. So I always say not every itch is yeast. If a patient has been treated for a yeast infection one to two times and continues to have symptoms, listen to the patient and order some testing. And that's why I said the molecular tests like the PCRs are readily available because the patient might not have a yeast infection. And the earlier we detect what is going on, we reduce delaying diagnosis or misdiagnosis and improve the patient's health overall.

Dr. Turck:
Well with those key takeaways in mind, I want to thank my guest, Dr. Tosin Goje, for joining me to discuss how we can improve our screening and diagnostic approach for patients with vulvovaginitis. Dr. Goje, it was great having you on the program.

Dr. Goje:
Thank you for having me.

Announcer:
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