

VAGINAL INFECTIONS: ANTIBIOTIC TREATMENT FOR

CANDIDIASIS

For more detail see Non-Notifiable Infections [Section 3.2.4 of the WA Health Dept Silver Book](#)

Or [Australian Therapeutic Guidelines: Antibiotic](#) search under Candida

- Asymptomatic infection does not require treatment
- Any of the imidazole preparations are effective, either as cream or pessaries. Various preparations are available for either single dose therapy, or three to seven days of therapy.
- Topical nystatin is a possible alternative.

Examples of possible treatments:

1. clotrimazole 10% vaginal cream 1 applicatorful intravaginally, as a single dose at night

OR

2. nystatin 100 000 units/5 g vaginal cream 1 applicatorful intravaginally, 12-hourly for 7 days.

- Prolonged use should be avoided as contact dermatitis may result.
- Where there is severe vulvitis associated with candidiasis, one per cent hydrocortisone preparations may be given WITH antifungal therapy. Note that unopposed steroids may exacerbate symptoms.
- Vaginal creams and pessaries may weaken latex condoms and diaphragms

Oral therapy

Oral therapy with fluconazole, including doses of 150mg-300mg has been associated with a statistically significant increase risk of spontaneous miscarriage compared with unexposed women and women with topical azole exposure in pregnancy. Oral treatments are no more effective than topical

preparations for uncomplicated infections.

Topical treatment must be used for 12-14 days in pregnancy because of lower response rates and more frequent relapse.

Generally, systemic treatment with fluconazole should be avoided in pregnancy

Fluconazole is considered teratogenic at higher continuous daily doses (> 400mg a day) as in utero exposure has resulted in a pattern of malformations similar to Antely-Bixler syndrome. Data suggests no increased risk of congenital anomalies after single doses of 150 mg. Decisions regarding fluconazole use in pregnancy require careful consideration of potential risks and benefits.

Refractory candidiasis

Some strains of candida are more resistant to treatment than others. In cases of refractory candidiasis the candida species should be identified by the laboratory. This will need to be requested on the pathology form, or the microbiology laboratory contacted to arrange. Candida glabrata which has failed treatment with imidazoles can be treated with boric acid 600 mg pessaries per vagina (one per night) for two weeks. These need to be manufactured. Seek specialist advice.

Recurrent candidiasis

4 or more episodes of symptomatic vaginal candidiasis occurring over 12 months may require a 2 step process.

Symptoms should be controlled with daily topical or oral therapy

e.g. clotrimazole 1% vaginal pessary or nystatin, intravaginally, at night

OR fluconazole 50 mg orally, once daily

Then relapse prevented with weekly maintenance therapy- either topical or systemic

e.g.

clotrimazole 500 mg pessary intravaginally, weekly

OR

nystatin 100 000 units/5 g vaginal cream 1 applicatorful intravaginally, weekly

OR

fluconazole 150 to 300 mg orally, weekly

TRICHOMONIASIS

See Non-Notifiable Infections [Section 3.14.4 of the WA Health Dept Silver Book](#):

Note: treatment of partner(s) is indicated

Standard

- Metronidazole 2 g orally, as a single dose

OR

- tinidazole 2 g orally, as a single dose with food

OR

- metronidazole 400 mg orally, 12-hourly for five days.

Advise avoidance of alcohol with either metronidazole or tinidazole treatment and for 24 hours thereafter. If there is relapse, the longer course of metronidazole may be required.

In Pregnancy

Trichomonas infection has been associated with adverse outcomes in pregnancy. Although treatment is generally advised, metronidazole therapy has not been proven to improve pregnancy outcomes.

- Metronidazole 400mg orally, 12-hourly for five days. Metronidazole can be used in the first trimester of pregnancy where benefits outweigh potential risks. (Some guidelines recommend that a single 2g dose of metronidazole is safe in pregnancy, others recommend the 5 day regimen in preference)

OR

- Clotrimazole 1% vaginal cream may be used for six days but is likely to be less effective

BACTERIAL VAGINOSIS

See **Non-Notifiable Infections** [Section 3.1.4 of the WA Health Dept. Silver Book](#)

Symptomatic cases should be treated. Treatment is not required for asymptomatic disease, as infection often resolves spontaneously, however treatment is recommended prior to gynaecological procedures and should be considered in pregnant women with history of preterm labour.

Standard/initial therapy

- Metronidazole 400mg orally, 12-hourly with food for five days
OR
- Metronidazole 2 g orally, as a single dose (less effective)
OR
- Metronidazole gel 0.75% gel 5g, nocte for five nights

OR
- Tinidazole 2g orally, as a single dose with food
OR
- Clindamycin 2% vaginal cream 5 g, daily for seven days
OR
- Clindamycin 300mg orally, 12-hourly for seven days

Advise avoidance of alcohol with either metronidazole or tinidazole treatment and for 24 hours thereafter. Clindamycin cream is oil-based and may weaken latex condoms and diaphragms.

Recurrent disease

Single dose therapy is not recommended.

Pregnancy

- clindamycin 300mg orally, 12-hourly for seven days

OR
- metronidazole 400mg orally, 12-hourly for five days. Metronidazole can be used in the first trimester of pregnancy where benefits outweigh potential risks.

Systemic treatment is usually advised in pregnancy.

REFERENCES (STANDARDS)

Silver Book Guidelines for Managing Sexually Transmitted Infections – WA (2013).
Govt of Western Australia Department of Health, Public Health

Therapeutic Guidelines: Antibiotic 14th Ed
Ditte Mølgaard-Nielsen, Henrik Svanström, Mads Melbye, Anders Hviid, Björn Pasternak. [Association between Use of Oral Fluconazole During Pregnancy and Risk of Spontaneous Abortion and Stillbirth.](#) *Jama*.2016;315(1):58-67

National Standards – 1 Clinical care is Guided by Current Best Practice
4 Medication Safety

Legislation - Nil

Related Policies - Nil

Other related documents – Nil

RESPONSIBILITY

Policy Sponsor	HOD Gynaecology
Initial Endorsement	October 2001
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Access the current version from the WNHS website**