"THE PELVIC EXAM REVISITED"
ERIN HIGGINS, MD, AND
CHERYL B. IGLESIA, MD (AUGUST 2017)

Pelvic examination is essential to clinical care

I have contemplated the issue of the routine screening pelvic exam now for several years. But for the last year, I have found various problems in many "asymptomatic women." For example: The 18-year-old who was "not sexually active" but who had *Chlamydia*. Or the 84-year-old who denied itching or other vulvovaginal symptoms who had either vulvar cancer or lichen sclerosis so severe her vagina was almost closed; a 30-minute review of her outside records revealed recurrent urinary tract infections requiring more than 5 courses of antibiotics in 6 months for what was actually contaminants from a urine specimen that passed through the vagina first. I think the move away from actually touching patients has completely gotten out of hand! It is appalling how many women I have seen who visited an emergency department for pelvic or abdominal pain and never had a hands-on examination. If we do not examine the part of the body that many completely ignore we may as well lose our specialty!

Christine Kneer-Aronoff, MD
Cincinnati, Ohio

"EFFECTIVE TREATMENT OF RECURRENT BACTERIAL VAGINOSIS"
ROBERT L. BARBIERI, MD
(EDITORIAL; JULY 2017)

Appreciates treatment options for recurrent BV

I thank Dr. Barbieri for his editorial on effective treatment of recurrent bacterial vaginosis (BV). I practice only outpatient gynecology, and recurrent

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BV is the most frustrating condition I have to deal with. Now I have 3 treatment options in my armamentarium for taking care of patients. I clipped the article pages from OBG MANAGEMENT and am keeping them available for easy access when needed.

I have a related question: I see trichomonal vaginitis rarely, maybe 1 to 2 cases in a year. What do you think the reason is?

Vimal Goyle, MD
New York, New York

Beyond BV: Candidiasis and diabetes medications

Thank you for addressing the recurrent BV problem. After many years of throwing antibiotics at this problem I have been underwhelmed. Patients do not want to keep chasing their tails between BV and yeast. I have been suggesting that patients place plain yogurt containing *Lactobacillus* in a tampon applicator and apply it to the vagina weekly at night, after the original "overgrowth" has been treated, to return the "good bacteria" to the vagina. This avoids overuse of antibiotics (an impending epidemic of resistant organisms), boric acid (a dangerous pill to have around toddlers), and the expense that comes with multiple visits and multiple courses of antibiotics. I believe that in Canada a vaginal ovule with vitamin C and probiotics is available (something to ponder).

Another problem is recurrent yeast infections. We are seeing that many new diabetes medications are increasing the clearance of glucose and are causing severe and intractable *Candida* vulvovaginitis. In addition, I would like to know the best topical treatments and skin care for yeast in the folds of the panniculus in the morbidly obese. Unfortunately, these patients often have poor or no insurance and therefore cannot afford the cost of many effective remedies.

John Lewis, MD
Bedford, Massachusetts

Another treatment protocol for BV

For recurrent BV, I treat with standard metronidazole 500 mg orally twice daily for 7 days, then immediately start boric acid suppositories for 3 days in a row followed by 1 weekly for 6 weeks, and that usually takes care of it. However, a few caveats: I instruct patients to keep a supply of boric acid suppositories on hand, and if they start to experience symptoms again, to repeat the 3-day, then weekly-for-6 weeks regimen, so essentially they can manage a recurrence themselves.

For patients who come in thinking they have a recurrent yeast infection or BV, which was initially treated elsewhere, I culture for *Mycoplasma* and *Ureaplasma*. I often find that one of those organisms is responsible for the infection, requiring completely different treatment.

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I also frequently check the vaginal pH, because patients like to see a visual on what I am talking about.

Rebecca Levy-Gantt, DO
Napa, California

Clindamycin appears superior for BV recurrence prevention

In my practice for the past number of years I have been treating BV with clindamycin vaginal cream instead of metronidazole. I have found that the number of women returning with recurrent BV has dropped dramatically. Furthermore, since switching medications, I cannot recall the last time someone required a maintenance dosing regimen. Although anecdotal, the difference between metronidazole and clindamycin treatment seems striking to me.

Daniel N. Sacks, MD
West Palm Beach, Florida

Uses BV regimens in stepwise fashion

To answer Dr. Barbieri's instant poll question, my preference for treating BV is to start off with Regimen 1 (metronidazole treatment followed by twice weekly vaginal metronidazole for 6 months), as described in his editorial. If problem reports resolve but recur at a later date, then I use Regimen 2 (metronidazole treatment plus 21 days of boric acid vaginal capsules followed by twice weekly vaginal metronidazole for 6 months). I am aware of Regimen 3 (single-dose oral metronidazole plus fluconazole followed by once-monthly metronidazole and fluconazole) but rarely use it.

Carole W. Campbell, DNP, CNM
Gadsden, Alabama

›› Dr. Barbieri responds

The readers of OBG Managment *are exceptional clinicians, and I appreciate the sharing of their insights in treating BV with our readers. Dr. Goyle reports that she commonly sees cases of BV but seldom sees cases of trichomoniasis. Two potential explanations for her observation are that her population of women has a low prevalence of trichomoniasis and/or that by using microscopy she is not detecting all the cases of trichomoniasis in her practice. In a recent large US study of women presenting with vaginitis, nucleic acid testing was used to identify the cause of the vaginitis.[1] The most common diagnoses were the following: 36%, bacterial vaginosis only; 24%, no detectable infection; 16%, candidiasis only; 14%, BV and candidiasis; 5%, BV and trichomoniasis; 4%, candidiasis and trichomoniasis; 1.5%, trichomoniasis only; and 0.7%,* Candida glabrata *only.[1] The most sensitive test for trichomoniasis is a nucleic acid test. Microscopy has low sensitivity for the detection of trichomoniasis.*

I agree with Dr. Lewis that for women with BV, lactobacilli and lactic acid treatment have an important role in establishing optimal vaginal flora that is resistant to recurrent infections. Dr. Lewis highlights the link between diabetes, some diabetes medications, and candidiasis. To treat Candida *in the folds of the panniculus, one option is multimodal topical therapy with compounded 2% ketoconazole, 2.5% hydrocortisone, and 1% iodoquinol in a cream base.*

Dr. Levy-Gantt offers a 4th option for treatment of chronic BV—initial metronidazole therapy followed by daily and then weekly use of boric acid vaginal suppositories.

Dr. Sacks reports that in his practice, clindamycin vaginal cream is significantly more effective than metronidazole for the treatment of BV. Most randomized studies comparing these 2 regimens reported no difference in efficacy.[2] Dr. Sacks may have uncovered a previously unreported resistance of organisms to metronidazole.

Dr. Campbell reports that Regimen 1 (metronidazole treatment followed by twice weekly vaginal metronidazole for 6 months) and Regimen 2 (metronidazole treatment plus 21 days of boric acid vaginal capsules followed by twice weekly vaginal metronidazole for 6 months) usually are effective in controlling recurrent BV. Our readers deeply appreciate the help of the clinicians who share their insights and clinical pearls.

References

1. Gaydos CA, Beqaj S, Schwebke JR, et al. Clinical validation of a test for the diagnosis of vaginitis. Obstet Gynecol. 2017;130(1):181–189.
2. Oduyebo OO, Anorlu RI, Ogunsola FL. The effects of antimicrobial therapy on bacterial vaginosis in non-pregnant women. Cochrane Database Syst Rev. 2009;(3):CD006055.

"CARING FOR THE TRANSGENDER PATIENT: THE ROLE OF THE GYNECOLOGIST"
CECILE A. UNGER, MD, MPH (JUNE 2017)

Calls for respect for transgender patients

We must keep in mind that transgender males are still sexually anatomically female, with all of the medical needs of any other female. Transgender is merely a social construct. We must treat them with kindness and respect.

Laurence Burns, DO
Grand Rapids, Michigan

WE WANT TO HEAR FROM YOU!

Share your thoughts on an article you read in this issue or on any topic relevant to ObGyns and women's health practitioners.

Contact us at **rbarbieri@frontlinemedcom.com**

Please include the city and state in which you practice.