Two-Drug BV Regimen Urged in Pregnancy

BY JANE SALODOF MACNEIL
Southwest Bureau

HOUSTON — Bacterial vaginosis in pregnant women requires a two-drug regimen to reduce the incidence of low-birth-weight and preterm babies, Dale Brown Jr., M.D., said at a conference on vulvovaginal diseases sponsored by Baylor College of Medicine.

Dr. Brown, chair of clinical affairs in the obstetrics and gynecology department at Baylor, said clinical studies involving single-drug therapy have failed to show a reduction in the incidence of low-birth-weight and preterm babies, because such therapy is not aggressive enough to prevent recurrence of bacterial vaginosis (BV).

"I just don't think that the single-drug treatment . . . is eradicating the organisms appropriately, because we know this vaginosis itself is a coterie of several types of organisms," he said. "If we allow any options for gram-negative organisms to take hold, that's why we continue to see" low-birth-weight babies and preterm deliveries.

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Dr. Brown estimated that 15%-20% of pregnant women are diagnosed with BV. They face a fivefold increased risk of late miscarriage in the second trimester, he said. While more than 30% of infections will spontaneously resolve, there is a high recurrence rate. Recurrence can be up to 30% in 3 months and 80% in 9-12 months in nonpregnant patients.

The American College of Obstetricians and Gynecologists has taken the position (in a practice bulletin) that "there are insufficient data to suggest screening and treating women at either low or high risk will reduce the overall rate of preterm birth" (Obstet. Gynecol. 2001;98:709-16).

For its part, the Centers for Disease Control and Prevention recommends BV screening in symptomatic pregnant women and asymptomatic pregnant women who are at high risk because they have previously delivered a premature infant. Treatment can be given to pregnant women who test positive for BV, the CDC says.

In contrast with the ACOG and CDC positions, Dr. Brown called for aggressive screening for BV in pregnant women regardless of their risk. All pregnant women should be screened early in pregnancy, he said. For those who test positive, he endorsed treatment before 20 weeks with an oral regimen recommended by the CDC. In addition, he advocated reevaluating high-risk women at every visit up to 32 weeks.

Dr. Brown said the ACOG and CDC guidelines were driven by evidence-based studies that tested one-drug treatments, whereas his opinion derived from clinical practice. He also cited the hypothesis that BV is an inflammatory condition as evidenced by increased levels of proinflammatory cytokines in women with BV (Obstet. Gynecol. 2003;102:527-34). Symptomatic women may be hyperresponders to BV, and asymptomatic women may be hyporesponders and also would benefit from aggressive treatment, Dr. Brown said.

The CDC recommends pregnant women be treated with 250 mg of metronidazole orally three times a day or 300 mg of clindamycin orally twice a day, both for 7 days, according to Dr. Brown. In addition, he advocated using a second agent, probably erythromycin or azithromycin. "*Gardnerella vaginalis* is not really attacked by metronidazole," he said.

If BV recurs, he recommended switching medications and using the new regimen for a longer period of time. Though randomized studies haven't shown improvement with treatment of the male partner, he advocated treating the partner as well. Among other management strategies for treating recurrent BV, he listed condoms, intravaginal use of *Lactobacillus crispatus*, oral or vaginal use of yogurt containing *L. acidophilus*, povidone iodine suppositories, hydrogen peroxide douches, lactate gel/acid preparation, and boric acid suppositories.

The underlying physiologic and pathologic conditions are not well understood, he said. He speculated that "some unknown factor involving interaction between vaginal bacteria" might be behind the perseverance of BV. ■

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