Longer BV Treatment Helps in the Short Term

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MONTEREY, CALIF. — Four strategies that have been proposed to improve treatment of bacterial vaginosis produced mixed results, with only an extended course of metronidazole improving cure rates, and that only in the short term, Dr. Jane R. Schwebke reported.

A double-blind study randomized 568 women with bacterial vaginosis (BV) to one of four treatment arms: daily metronidazole for 7 days; metronidazole for 14 days; metronidazole for 7 days plus 1 g azithromycin on days 1 and 3, or metronidazole for 14 days plus azithromycin on days 1 and 3. The metronidazole was given in 750-mg extended-release form.

At a first follow-up visit 7 days after completion of treatment, BV was cured in 63% of patients who took metronidazole for 14 days, compared with 45% of patients who took metronidazole for 7 days. By a second follow-up 21 days after completing treatment, however, there was no significant difference in cure rates among any groups. Azithromycin therapy did not seem to make a difference at either time point, Dr. Schwebke and her associates reported in a poster presentation at the annual meeting of the Infectious Diseases Society for Obstetrics and Gynecology.

Any benefit from the longer course of metronidazole in the short term was lost in the long term. "We don't know if that's because of relapse or reinfection," she said in an interview at the meeting.

Some physicians have advocated using 10-14 days of metronidazole to treat recurrent BV, though they lacked supportive data. Others have suggested the relatively low cure rates of 50%-80% seen when treating BV with metronidazole or clindamycin may be due to resistant organisms that are susceptible to macrolide antibiotics, such as mycoplasmas and *Mobiluncus curtisii,* noted Dr. Schwebke, professor of medicine at the University of Alabama, Birmingham, and her associates.

Patients with a Nugent score at baseline of 5-8 (less complicated flora) were more likely to be cured than were those scores of 9-10, the intent-to-treat analysis found. ■

Thrombophilia Screening Is Questioned

LISBON — There is absolutely no reason today to universally screen pregnant women for inherited thrombophilias, Dr. Ian A. Greer said at the 15th World Congress of the International Society for the Study of Hypertension in Pregnancy.

Although easy and accurate tests for inherited thrombophilias are available, the best management of women who have these disorders remains unclear. A systematic review of the literature turned up results from just one randomized, controlled trial showing that pregnant women with a thrombophilia—in this case, antiphospholipid syndrome—had a modest benefit from treatment with aspirin and heparin, said Dr. Greer, professor of obstetrics and gynecology at the University of Glasgow, Scotland. But antiphospholipid syndrome is an acquired, not inherited, thrombophilia and no other results from randomized, controlled trials in women with a thrombophilia have been reported, he said.

Although aspirin, unfractionated heparin, and low-molecular-weight heparin are all treatment options, alone or in combination, not enough evidence currently exists to recommend any specific regimen over the others.

Dr. Greer and his associates have run a cost-effectiveness analysis of thrombophilia screening and treatment, using a hypothetical, representative population of 10,000 pregnant women. They assumed that treatment with low-molecular-weight heparin would have an 80% efficacy for preventing adverse maternal and fetal outcomes, including intrauterine growth restriction, miscarriage, and preeclampsia.

In this analysis, the cost for preventing a single adverse event through universal screening would be about $90,000. The cost to prevent a single adverse event would be about $80,000 using selective screening of women with a personal or family history of thrombophilia or a history of venous thromboembolism, Dr. Greer said.

—Mitchel L. Zoler

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