The normal anatomy, physiology and microbial ecology of the vagina are age-dependent as are the sources of vaginal infections. In the neonatal period, the vagina is influenced by maternal oestrogen and has a stratified squamous epithelium. Later, and until puberty, the vagina is lined by cuboidal cells and the pH is around 7.0. Following puberty, oestrogen causes a change to stratified squamous epithelium. The predominant microbial flora at this age are lactobacilli such as *L. crispatus* and *L. jensenii*, which produce lactic acid, and the pH falls to 4.0 - 4.5. The other vaginal flora include diphtheroids, β-haemolytic streptococci, coliforms and coagulase-negative staphylococci.1

**VAGINAL DISCHARGE IN PRE-PUBERTAL GIRLS**

Vaginal symptoms including a discharge in pre-pubertal girls ought to be investigated microbiologically as the sexually transmitted (ST) pathogens *Neisseria gonorrhoeae* and *Chlamydia trachomatis* may be isolated.2 Other non-ST pathogens include β-haemolytic streptococci Group A (*S. pyogenes*), *Shigella flexneri* and *Enterobius vermicularis*.

**VAGINAL DISCHARGE IN POST-PUBERTAL WOMEN**

Vaginal infection is one of the top 25 reasons for women to consult doctors in the USA. The 3 most common types of vaginal infections include bacterial vaginosis, trichomoniasis and candidiasis and these may or may not be associated with cervical infection. Other vaginal syndromes are due to chemical toxins or physical agents (Fig. 1).

**VAGINAL DISCHARGE IN POSTMENOPAUSAL WOMEN**

In this age group, the vaginal epithelium becomes thin along with an increase in pH. Besides ST pathogens, a number of chronic vulvovaginal syndromes occur. An important one is desquamative inflammatory vaginitis, a syndrome associated with purulent vaginal discharge, vaginal cell exfoliation, increase in pH and Gram-positive cocci being observed in vaginal fluid. This syndrome responds to 2% clindamycin cream intravaginally.3

**VAGINAL DISCHARGE IN ADULT WOMEN**

Of the 3 common infective causes of vaginal discharge, bacterial vaginosis is the commonest. However, in certain populations trichomoniasis may be as common. Yeast infections also occur commonly and host factors ranging from genetic to acquired such as pregnancy, diabetes mellitus, use of corticosteroids, immunosuppressive therapy and systemic antimicrobials may predispose to colonisation and infection.

A summary of the symptoms, signs and diagnostic features of common vaginal infections in adult women is presented in Table I.
Vaginal symptoms including discharge in pre-pubertal girls ought to be investigated microbiologically as the sexually transmitted (ST) pathogens Neisseria gonorrhoeae and Chlamydia trachomatis may be isolated.

Of the 3 common infective causes of vaginal discharge, bacterial vaginosis is the commonest. However, in certain populations trichomoniasis may be as common. Yeast infections also occur commonly and host factors ranging from genetic to acquired such as pregnancy, diabetes mellitus, use of corticosteroids, immunosuppressive therapy and systemic antimicrobials may predispose to colonisation and infection.

### Bacterial vaginosis

Bacterial vaginosis (BV) is the result of overgrowth of the resident vaginal flora, which comprises Gardnerella vaginalis, Mobiluncus, Bacteroides, and Prevotella species and Mycoplasma hominis. There is simultaneous loss of the normal resident lactobacilli of the vagina. There is no inflammation of the vaginal epithelium and therefore BV represents a change in the vaginal ecosystem. The cause for this overgrowth is unknown. It is felt that normal vaginal lactobacilli are hydrogen peroxide (H$_2$O$_2$)-producing and this restricts proliferation of the organisms associated with BV. A loss in H$_2$O$_2$-producing lactobacilli leads to the development of BV.

The bacterial overgrowth in BV results in production of amines by anaerobes and when potassium hydroxide is added to the vaginal fluid, a typical fishy odour is produced. The bacterial amines together with organic acids such as acetic and succinic are cytotoxic leading to exfoliation of vaginal epithelial cells. G. vaginalis adheres to exfoliated epithelial cells and this creates shaggy-looking clue cells, which are a characteristic feature of BV.

BV was previously considered to be merely an inconvenience for women. However, there is increasing evidence linking BV with adverse outcomes in pregnancy, such as chorioamnionitis, preterm labour, prematurity and post-partum fever. The diagnosis of BV is made using bedside tests fulfilling at least 3 of the following criteria:

- presence of grey, white homogenous discharge
- positive amine test (addition of 1 drop of 10% KOH to 1 drop of vaginal secretions releasing a characteristic fishy odour)
- vaginal pH > 4.5 and presence of clue cells on microscopic examination of vaginal secretions or by performance of a Gram stain on vaginal secretions and using a scoring system proposed by Nugent et al. A score of 7 is diagnostic of BV; 3 is negative and 4 - 6 indicates an indeterminate diagnosis. Cultures of G. vaginalis do not offer any advantage for diagnosis, as they are positive in nearly 60 - 70% of women without infection.

Ampicillin has been used with some success. However, the drug of choice

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### Fig. 1. Overview of the aetiology of vaginal discharge in adult women.
is metronidazole (Table II). The majority of studies have shown better response and fewer recurrences with multiple-dose therapy, rather than a single 2 g dose.

The treatment of asymptomatic BV is recommended in pregnancy especially in women with poor obstetric histories.

**Trichomoniasis**

Trichomoniasis is a sexually transmitted infection (STI). The prevalence of trichomoniasis in South African women ranges from 5% to 49% in the different groups studied. Higher prevalences appear to occur in pregnant women. Being an STI, trichomoniasis commonly occurs together with gonorrhoea and chlamydia.

The main vaginal defence mechanism is production of local vaginal leucocytes, which attempt to kill the causative agent. The virulence mechanism of *Trichomonas vaginalis* is poorly understood and it is felt that the protozoan destroys epithelial cells by direct contact.

The clinical features of infection range from asymptomatic to profuse malodorous vaginal discharge. The characteristic feature is a frothy greenish-yellow, purulent discharge. The vaginal walls are erythematous and in severe infection, punctuate haemorrhages on the ectocervix give the cervix a strawberry appearance. Untreated trichomoniasis in pregnancy may predispose to premature rupture of membranes.

Diagnosis is by demonstration of the organism by wet smear microscopy or staining techniques such as acridine orange, Giemsa, etc. or by culture in media such as modified Diamond’s. Wet smear microscopy relies on visualisation of flagellated, pear-shaped protozoa with their characteristic jerky movement in the presence of numerous leucocytes (Table I).

Treatment of trichomonal infection is with metronidazole or tinidazole. Metronidazole is the commonest nitroimidazole currently used for therapy. Oral therapy is preferred because there is concurrent infection of the urethra and periurethral glands. Single-dose therapy of 2 g oral metronidazole has shown cure rates of greater than 90% and is preferred as it ensures compliance. Disadvantages of the single-dose regimen are nausea, a metallic taste in the mouth, disulfiram-like effect with alcohol and also the need to treat sexual partners simultaneously. Treatment in early pregnancy is a problem because of the safety of metronidazole, and in such a setting the use of vaginal clotrimazole or povidone iodine may be beneficial.

**Candidiasis**

Prevalence studies from developed countries show yeast infections to be the second most common cause of vaginal infections while these appear to be the least common of the 3 main
causes of infection in women in developing countries. Candida albicans is the most common species of yeast isolated from the vagina (±90%) while C. glabrata and C. tropicalis are found less frequently. The germination of yeast forms enhances colonisation and tissue invasion. Pregnant women are predisposed to infection, especially in the third trimester, as are women on oral contraceptives, systemic antibiotics, corticosteroid or immunosuppressive therapy and those with uncontrolled diabetes mellitus.

The common presenting symptom is vulval itching and irritation. There may also be soreness, vulval burning, dyspareunia and dysuria.

Recurrent candidal vaginitis may be due to a number of factors but it is difficult to identify the exact precipitating mechanism. More than one host factor may be involved and there is no evidence of defect in local immunity. For the prevention of recurrent candidiasis in women using systemic antibiotics, an oral antifungal should be used weekly, e.g. 100 mg fluconazole.

The discharge of candidiasis is curd-like and adherent due to direct hyphal invasion of epithelial tissues resulting in erythema of the vaginal epithelium. Clinical diagnosis is easily confirmed by doing a wet saline mount or 10% potassium hydroxide (KOH) preparation (Table I). Cultures may be performed in cases where microscopy is negative.

For the management of vulvovaginal candidiasis various topical formulations such as creams, pessaries, tablets, ovules, etc. are available. There is no evidence favouring any particular formulation or any particular azole preparation. However, in the presence of vulval inflammation local application of a cream is beneficial. There is also a marginal benefit of using azole preparations over the polyene, nystatin. For ensuring compliance, there is a trend towards using higher antifungal doses for a shorter duration. Some commonly available preparations are shown in Table III.

The oral agents for the treatment of vulvovaginal candidiasis include ketoconazole (400 mg for 5 days), itraconazole (200 mg bd for 1 day) and fluconazole (150 mg single dose). The latter is the only single-dose regimen recommended. These agents may be preferred by patients for convenience but should not be prescribed in pregnancy. Ketoconazole has been associated with hepatotoxicity and caution should be exercised when using this agent.

Women who have recurrent vulvovaginal candidiasis may have predisposing factors, which need to be addressed. However, in many women with recurrent infection, no underlying or predisposing factors are identified. These women are best managed with long-term suppressive prophylaxis and this may be achieved with a weekly dose of 100 mg fluconazole or weekly vaginal insertion of 500 mg clotrimazole.

**CERVICITIS**

Cervicitis implies an infection of the cervix and this may be either an ecto-cervicitis due to ST pathogens such as...
herpes simplex virus or *T. vaginalis* or an endocervicitis also called mucopurulent cervicitis (MPC) due mainly to *N. gonorrhoeae* and *C. trachomatis*. The presence of a purulent exudate from the cervical os has been highly associated with *N. gonorrhoeae* and *C. trachomatis* infection. An important pathogen which also infects the cervix is the human papillomavirus but this is not associated with cervicitis.

The risk factors for endocervical infection are the same for all ST pathogens, namely young age, unmarried persons, lower socioeconomic status, increased number and recent changes in sexual partner, prostitution and drug use. Cervicitis may be asymptomatic and detected only during speculum examination, or it may be recognised in the presence of concurrent vaginal discharge. However, occasionally mucopurulent cervicitis may produce a vaginal discharge on its own. A clinical diagnosis may be helped by detecting friability of the cervix or contact bleeding when examining with a swab and with the visualisation of a greenish-yellow exudate. The two-swab test has also been proposed for symptomatic women, i.e. the use of the first swab for removal of cervical mucus and insertion of the second swab into the endocervical canal, then removing it and observing for a colour change against a white background. The laboratory test for diagnosing MPC is based on a simple Gram stain of the cervical exudate, which yields ≥ 30 polymorphonuclear cells per high-power field. To detect the underlying cause one has to use more definitive tests such as culture, antigen detection and molecular assays such as DNA probe tests and polymerase chain reaction (PCR). The diagnosis of gonococcal infection can easily be made with culture, but for diagnosing chlamydial infection, culture alone is not sensitive. The newer molecular tests such as PCR are popular as they are more sensitive, specific and even allow for testing on non-invasive specimens such as initial stream of urine, self-administered swabs and tampons (Table IV).

**Antimicrobial agents currently recommended for the management of endocervicitis or mucopurulent cervicitis are as follows:**

- For *N. gonorrhoeae* — either a quinolone in a single-dose regimen, e.g. ciprofloxacin 500 mg, ofloxacin 400 mg or a parenteral preparation, e.g. ceftriaxone 125 mg as an intramuscular injection.
- For *C. trachomatis* — oral preparations of a macrolide, e.g. erythromycin 500 mg qid for 7 days or tetracycline, e.g. doxycycline 100 mg bd for 7 days or a single 1 g dose of azithromycin.
- For herpes simplex infection — acyclovir 400 mg tid for 10 days for a primary episode and for 5 days for recurrence, or valaciclovir 500 mg bd for 10 days and for 5 days for recurrence.

### MANAGEMENT PROTOCOL

**Comprehensive investigation and management**

All patients with a complaint of vaginal discharge ought to have a speculum examination to determine whether the vagina alone or the vagina and cervix are affected. This also assists in specimen collection for bedside and laboratory tests. These investigations and the respective management strategies have been discussed above.

**Syndromic management**

In view of the inability to carry out extensive, comprehensive assessment of patients presenting to primary health care facilities in many public health clinics, there is a dire need to provide adequate care in an organised, structured manner. Syndromic management has been widely advocated world-wide for developing communities, and allows management of patients at the time of first contact, ensuring treatment of the most likely causes. This also allows time to comply with the 4Cs for prevention of STIs: counselling, condom promotion, contact management and encouraging compliance.

The protocol for syndromic management of vaginal discharge according to the National Department of Health (Directorate for HIV/AIDS and STDs) is presented in Fig. 2.

**References available on request.**
**VAGINAL DISCHARGE SYNDROME**

Patient complains of vaginal discharge/dysuria or vulval itching/burning

Take history and examine (external genitalia and bi-manual, use speculum)

Abnormal discharge or vulval itching or burning → NO

Any other STI syndrome → YES

Use appropriate flow chart, manage appropriately

Lower abdominal tenderness or pain?

YES → Abnormal discharge or vulval itching or burning

NO → NO

NO → YES

Use lower abdominal pain flow chart

Treat with:

- Ciprofloxacin 500 mg stat
- Doxycycline 100 mg 2 x daily for 7 days
- Metronidazole 2 g stat

*In pregnancy / during breast-feeding:*

- Ceftriaxone 125 mg imi stat
- Erythromycin 500 mg 4 x daily for 7 days
- Metronidazole 2 g stat

If vulval oedema/curd-like discharge, erythema, excoriations present, add:

- Cotrimazole vaginal pessary 500 mg inserted stat

Ask patient to return in 7 days if symptoms persist

Symptoms/signs improved?  
Re-infection (new episode)?  
Poor compliance?

NO → Treatment failure: Refer second level of care

YES → Repeat treatment

**ALL PATIENTS:**

- Educate, ensure compliance, and counsel
- Promote abstinence from penetrative sex during the course of treatment
- Promote and demonstrate condom use, provide condoms
- Stress the importance of partner treatment and issue one notification slip for each sexual partner, follow up partner treatment during review visits
- Promote HIV counselling and testing, for negative test results repeat test after 3 months

*Fig. 2. Protocol for syndromic management of vaginal discharge.*
VAGINAL DISCHARGE

IN A NUTSHELL

Vaginal discharges are a common problem in adult women. The discharges may be physiological or pathological. The common pathological causes are due to infection occurring in the cervix (cervicitis) or in the vagina (vaginitis and vaginosis). The common causes of endocervicitis are the sexually transmitted pathogens of Neisseria gonorrhoeae and Chlamydia trachomatis. The important causes of vaginal infection are trichomoniasis due to Trichomonas vaginalis, candidiasis due to Candida albicans and bacterial vaginosis due to proliferation of endogenous vaginal flora of Gardnerella vaginalis, anaerobes and Mycoplasma hominis.

Bedside tests of pH determination, whiff test and wet smear microscopy can easily diagnose vaginal infection. Laboratory tests are required to confirm the causes of endocervicitis or mucopurulent cervicitis (MPC).

Syndromic management of vaginal discharge attempts to treat both cervical and vaginal causes.

Syndromic management is widely acclaimed for use in developing communities as it covers the common causes of infection at the point of first contact.

SINGLE SUTURE

CANNABIS RELIEVES SYMPTOMS OF MS — BUT ONLY JUST

In what has been described as a ‘limited victory for medical cannabis’ Zajicek and colleagues have published a paper in The Lancet which claims that cannabis relieves the subjective symptoms of multiple sclerosis (MS). Patients with MS received either a delta-9-tertahydrocannabinol (THC), or cannabis extract or placebo. Standard objective tests to measure spasticity suggested that the drugs were no more effective than placebo. But, 60% of patients receiving cannabis reported improvements in spasticity compared with 46% on placebo. Pain relief was also an important effect noted by those on cannabis.

As Zajicek points out, there is now as much evidence to support the use of cannabis as there is for more conventional treatments such as baclofen. The Lancet asks the question — will attitude continue to limit the use of cannabis? Difficult to say, particularly when use and possession of cannabis is still illegal in most countries.