### Genital Tract Infections

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<th>Clinical diagnosis</th>
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| **Bacterial vaginosis** | Metronidazole 400 mg BD for **7 days OR 2 g STAT** dose  
**Note** there is greater relapse with 2 g dose  
*If pregnant or unable to abstain from alcohol:* Metronidazole 0.75% vaginal gel 5 g applicatorful at night for **5 nights OR** Clindamycin 2% cream 5 g PV at night for **7 nights**  
Avoid Metronidazole 2 g dose in pregnancy. | Refer to GUM or Sexual Health Services if diagnosis is uncertain or the infection is recurrent or troublesome. |

* Avoid in pregnancy

| **Candida balanitis** | Clotrimazole cream 1%. Apply 2-3 times a day for **2 weeks** | Check for underlying problems |

| **Candidiasis, vaginal** | Fluconazole* 150 mg oral **STAT** dose OR Clotrimazole pessary 500 mg OR Clotrimazole 10% vaginal cream **NOCTE STAT**  
**AND** Clotrimazole 1% cream TDS for **7 days** | Investigate recurrent cases (4 or more episodes annually) and refer if appropriate. |

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### Clinical diagnosis | Treatment advice | Comments and guidelines for lab testing
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**Chlamydia**<br>أشياء أخرى<br>BNFC Doxycycline<br>BNFC Azithromycin<br>BNFC Erythromycin<br>BNFC Amoxicillin | *First line:* Doxycycline* 100 mg BD for 7 days<br>*Second line:* Azithromycin† 1 g STAT, followed by 500 mg OD for 2 days<br>**If at risk of pregnancy or breastfeeding:**<br>Azithromycin† 1 g STAT, followed by 500 mg OD for 2 days (recommended first line, most effective, but off-label) OR<br>Erythromycin 500 mg QDS for 7 days OR<br>Erythromycin 500 mg BD for 14 days OR<br>Amoxicillin 500 mg TDS for 7 days<br>Pregnant patients should be given a test of cure 3 weeks after completing therapy, regardless of the antibiotic used, due to lower cure rate in pregnancy.<br>*For suspected epididymitis in men:* Ofloxacin 200 mg BD 14 days OR<br>Doxycycline 100 mg BD 14 days<br>*If risk of rectal infection:* Doxycycline* 100 mg BD for 7 days<br>For example, all women, and men who have sex with men. Patients and any partners should be referred to GUM even if treated locally.<br>* Avoid in pregnancy<br>† The use of azithromycin is appropriate for the treatment of chlamydia in pregnancy. | Doxycycline* is now recommended first line. Emerging co-infection with macrolide resistant *Mycoplasma genitalium* is likely due to widespread use of azithromycin†.<br>Treat partners and refer to local Sexual Health or GU service.<br>Look for signs of PID or epididymitis and refer to appropriate guidance.<br>Offer and encourage full STI screening. If gonorrhoea is not excluded, use of azithromycin† alone may contribute to the development of resistance.<br>Advise patients to refrain from any sexual activity until they and their partner(s) have completed treatment or, in the case of Azithromycin, one week after the STAT dose.<br>Note May be asymptomatic or mild symptoms of infection

**Endometritis, postpartum or following gynaecological procedure or surgery**<br>أشياء أخرى<br>BNFC Co-amoxiclav<br>BNFC Cefalexin<br>BNFC Metronidazole | New or changed and offensive discharge within 10 days post-partum or post-gynae procedure: Co-amoxiclav 500/125 mg TDS for 7 days<br>*In non-severe penicillin allergy:* Cefalexin 500 mg TDS AND<br>Metronidazole 400 mg TDS for 7 days | Refer patients with significant systemic symptoms or if symptoms fail to improve after 7 days
### Clinical diagnosis

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| **Epididymitis or epididymo-orchitis**     | If > 35 years old and there is low suspicion of STI treat empirically.  
*If likely enteric organisms*: Ciprofloxacin 500 mg BD for **14 days** OR Ofloxacin 200 mg BD for **14 days**  | Sexual history is imperative.  
If < 35 years old or if high suspicion of sexually transmitted infection at any age refer to GUM or Sexual Health services.  
Submit MSU  
Recent investigations or catheterisation are risk factors.  
All patients with sexually transmitted epididymo-orchitis should be screened for other sexually transmitted infections. Sexual partners will also need treatment and screening.  
All patients with urinary tract pathogen confirmed epididymo-orchitis should be investigated for structural abnormalities and urinary tract obstruction by a urologist. |
| **Episiotomy or Caesarean section wound infection** | Co-amoxiclav 500/125 mg TDS for **7 days**  
*In non-severe penicillin allergy*: Cefalexin 500 mg TDS AND Metronidazole 400 mg TDS for **7 days** | Refer all people with suspected gonorrhoea to a GUM clinic or other local specialist sexual health service for culture, treatment, and partner notification. |
| **Gonorrhoea**                             | Aciclovir 400 mg TDS for **5 days**                   | Treat if suspected based on clinical appearance and history.  
It may be preferable to initiate treatment in primary care if there would be a delay of > 24 hours until the patient was assessed in GUM or Sexual Health Service. |
| **Herpes, genital** (primary cases only)   | Aciclovir 400 mg TDS for **5 days**                   | Refer all patients to GUM or Sexual Health Service for virological confirmation.  
Phone local department same day  
☎ BNFC Aciclovir  
☎ BASHH |

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**Pan Mersey Area Prescribing Committee**
### Pelvic sepsis or pelvic inflammatory disease

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<td>Metronidazole 400 mg BD for <strong>14 days</strong> AND Ofloxacin* 400 mg BD for <strong>14 days</strong></td>
<td>Consider Chlamydia infection. MUST be referred to GUM or Sexual Health Services for contact tracing and follow-up. It may be preferable to initiate treatment in primary care if there would be a delay of &gt; 24 hours until the patient was assessed by GUM or Sexual Health Service. If gonorrhoea likely, refer to GUM or Sexual Health Service. Consider gynaecological referral if systemically unwell.</td>
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* Avoid in pregnancy

**Under review**

- BASHH 2019 Update
- BNFC Ofloxacin
- BNFC Metronidazole

### Trichomoniasis

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<td>Trichomoniasis</td>
<td>Metronidazole 400 mg BD orally for <strong>7 days</strong> OR 2 g STAT* dose</td>
<td>MUST be referred to GUM or Sexual Health Services for contact tracing and follow-up. Sexual partners should be treated simultaneously.</td>
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* Avoid in pregnancy

**In pregnancy or breastfeeding:**

Avoid **2 g single dose** of Metronidazole. Consider Clotrimazole 100 mg pessary at night for **6 nights** for symptom relief. Clotrimazole has **no activity** against **Trichomonas** and should only be considered if Metronidazole is refused. **Important** alleviating symptoms without treating the infection will only delay accessing treatment and risk complications and onward transmission.

### Vaginal discharge in children

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<td>Vaginal discharge in children</td>
<td>Be guided by swab and culture sensitivity as often unexpected pathogens such as <em>H influenzae</em>, pneumococci or group A streptococci are present.</td>
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Consider all possible causes including foreign bodies and abuse. If abuse suspected refer urgently to paediatricians and consider safeguarding issues.