Genital tract infections in adults

Prescribing information: these guidelines do not include all the prescribing information for all the drugs. Please refer to the BNF or consult a pharmacist for appropriate use in specific populations, for example, hepatic impairment, renal impairment, pregnancy and breastfeeding.

Self-care: treatments marked as [OTC] are available to buy from pharmacies. Patients can be advised to purchase them as self-care where appropriate.

Bacterial vaginosis

Oral metronidazole is as effective as topical treatment and is more cost effective. Less relapse with 7 days oral metronidazole treatment than 2 g stat dose at 4 weeks.

Pregnant or breastfeeding: avoid 2 g stat dose.

Treating partners does not reduce relapse.

Advise: do not use vaginal douches, bubble bath, shower gel or shampoo in the bath or strong detergents to wash your underwear.

Laboratory testing: bacterial vaginosis can be diagnosed by high-vaginal swab and Gram stain performed by the laboratory. The presence of clue-cells is diagnostic of bacterial vaginosis. Note bacterial vaginosis can be asymptomatic – the coincidental finding of clue cells in asymptomatic patients does not require treatment.

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First line: oral metronidazole 400 mg BD for 7 days or 2 g STAT dose.

If pregnant or unable to abstain from alcohol: metronidazole 0.75% vaginal gel one 5 g applicatorful at night for 5 nights **or alternatively**
clindamycin 2% cream 5 g PV at night for 7 nights.

After first line treatment is ineffective or not tolerated as an alternative to clindamycin: dequalinium chloride vaginal tablet 10 mg inserted at night for 6 nights.

Balanitis

Check for any underlying problems.

Avoid soap, bubble bath or other irritant. Instead advise use of a soap substitute. Advise that topical imidazole preparations may damage latex condoms and diaphragms.

If inflammation is causing discomfort, consider prescribing topical hydrocortisone 1% cream or ointment for up to 14 days in addition.

Laboratory diagnosis: penile swab if pus present

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Candida: clotrimazole 1% cream BD/TDS until symptoms settle or for up to 14 days **or**
oral fluconazole 150 mg STAT dose.

Bacterial: oral flucloxacillin 500 mg QDS for 7 days.

Penicillin allergy: oral clarithromycin 250 mg BD for 7 days.

Anaerobic (*Gardnerella*): oral metronidazole 400 mg BD for 7 days.

Candidiasis, vaginal

All topical and oral azoles give over 80% cure.

Concurrent vulvitis: add 2% clotrimazole cream.
If treating with clotrimazole 500 mg pessary, prescribing a Combi pack is less expensive than separate prescriptions for pessary and cream.

If pregnant: avoid oral azoles and may need a longer duration of treatment, usually about 7 days to clear the infection.

Laboratory diagnosis: not indicated unless severe or recurrent infection

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First line: [OTC] oral fluconazole 150 mg STAT dose **or**
[OTC] clotrimazole 500 mg pessary STAT dose **or**
[OTC] clotrimazole 100 mg pessary at night for 6 nights.

In pregnancy: clotrimazole 100 mg pessary at night for 6 nights (without applicator).

Recurrent (> 4 episodes per year): oral fluconazole 150 mg every 72 hours for 3 doses, then 150 mg dose once a week for 6 months maintenance.

Chlamydia trachomatis/urethritis

Offer and encourage full STI screening to patients aged 15 to 24 years for chlamydia annually, and on change of sexual partner. If positive, treat patient and partner, and refer to GUM or local sexual health clinic.

Advise to refrain from sexual activity until doxycycline course is complete or for 7 days after treatment with azithromycin. Test for reinfection 3-6 months following treatment if under 25 years or for over 25 years and high risk.

Pregnancy/breastfeeding/allergy/intolerance: test for cure at least 3 weeks after the end of azithromycin treatment.

Symptomatic urethritis: consider referring to GUM to test for *Mycoplasma genitalium* and *Gonorrhoea* (see separate sections).

Laboratory testing: if suspected chlamydia, send chlamydia nucleic acid amplification test (NAAT) in viral transport media.

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Non-pregnant
First line: doxycycline 100 mg BD for 7 days.

Second line: azithromycin 1 g STAT dose, then 500 mg OD for 2 days (3 days total).

Third line: ofloxacin 200 mg BD or 400 mg OD for 7 days.

Pregnant/breastfeeding/allergy/intolerance
First line: azithromycin 1 g STAT dose, then 500 mg OD for 2 days (3 days total).

Second line: erythromycin 500 mg QDS for 7 days **or**
amoxicillin 500 mg TDS for 7 days.

Endometritis, postpartum or following gynaecological procedure or surgery

Endometritis is a potentially severe postpartum infection that most often requires hospitalisation and IV antibiotic treatment. Mild cases and late onset postpartum endometritis (>7 days) usually can be treated with PO antibiotics. In late onset cases Chlamydia testing is required. Refer patients with significant systemic symptoms or if symptoms fail to improve after 7 days Last updated: Jan 2020	*Chlamydia negative* **First choice**: co-amoxiclav 500/125 mg TDS for 7 days. **Non-severe penicillin allergy**: cefalexin 500 mg TDS for 7 days **and** metronidazole 400 mg TDS for 7 days. **Severe penicillin allergy**: clindamycin * 450 mg QDS for 7 days * Clindamycin is present in breast milk. Use with caution in breastfeeding women. Infant needs to be monitored for effects on the gastrointestinal flora such as diarrhoea and candidiasis. *Chlamydia positive* **If breastfeeding**: metronidazole 400 mg TDS for 7 days **and** either erythromycin 500 mg QDS for 7 days or azithromycin 1000 mg STAT then 500 mg OD for 2 days (total 3 days). **If not breastfeeding:** doxycycline 100 mg BD for 7 days **and** metronidazole 400 mg TDS for 7 days

Epididymitis

Usually in men over 35 years with low risk of STI. If under 35 years or STI risk, refer to GUM or local sexual health clinic. **Laboratory testing**: all patients with sexually transmitted epididymitis should be screened for other STI infections. Sexual partners will also need treatment and screening. Occasionally an MSU is useful identifying the causative agent (non-STI aetiologies) Last updated: Jan 2020	**First line**: doxycycline 100 mg BD for 14 days **or** ofloxacin 200 mg BD for 14 days **or** ciprofloxacin 500 mg BD for 10 days.

Episiotomy or Caesarean section wound infection

Refer patients with moderate or severe symptoms or if symptoms fail to improve after 7 days. If there is clinical deterioration or no response then admission for IV antibiotics should be considered.

If the woman is colonised with MRSA or thought to be at high risk (e.g. healthcare professional), then discuss with Microbiology.

Breastfeeding: antibiotics listed can be used in breastfeeding when used short term.

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First line: co-amoxiclav 500/125 mg TDS for 7 days.

Non-severe penicillin allergy: cefalexin 500 mg TDS for 7 days **and** metronidazole 400 mg TDS for 7 days.

Severe penicillin allergy: clindamycin * 450 mg QDS for 7 days
* Clindamycin is present in breast milk. Use with caution in breastfeeding women. Infant needs to be monitored for effects on the gastrointestinal flora such as diarrhoea and candidiasis.

Severe penicillin allergy and clindamycin is not suitable: erythromycin 500 mg QDS for 7 days **and**
metronidazole 400 mg TDS for 7 days

Genital herpes

Advise: saline bathing, analgesia, or topical lidocaine for pain, and discuss transmission.

First episode: treat within 5 days if new lesions or systemic symptoms and refer to GUM. May need to start treatment in primary care if there would be a delay of > 24 hours until patient will be assessed in GUM or sexual health clinic.

Recurrent: if attacks are infrequent (< 6 attacks per year) use self-care if mild or give an immediate short course of treatment. If attacks are frequent (> 6 attacks per year), or causing psychological distress, or affecting the person's social life consider suppressive treatment.

Pregnancy: seek specialist advice.

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First episode treatment: oral aciclovir 400 mg TDS for 5 days **or**
valaciclovir 500 mg BD for 5 days

Recurrent treatment: oral aciclovir 800 mg TDS for 2 days **or**
valaciclovir 500 mg BD for 3 days **or**
famciclovir 1 g BD for 1 day (expensive)

Suppressive treatment: oral aciclovir 400 mg BD **or**
valaciclovir 500 mg once a day **or**
famciclovir 250 mg BD (expensive)

If breakthrough reoccurrence occurs, the dose should be increased. Seek microbiology advice.

Continue treatment for a maximum of one year, then stop and reassess reoccurrence (for a minimum of 2 reoccurrences). Consider restarting treatment in people with high rates of reoccurrence with advice from microbiology.

Gonorrhoea

Antibiotic resistance is now very high. Test of cure is essential.

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Refer to GUM or sexual health clinic for advice and treatment.

Pelvic inflammatory disease

Refer women and sexual contacts to GUM or local sexual health clinic. **Exclude**: ectopic pregnancy, appendicitis, endometriosis, UTI, irritable bowel, complicated ovarian cyst, functional pain. Moxifloxacin has greater activity against likely pathogens, but always test for *Gonorrhoea*, chlamydia, and *M. genitalium*. **Ceftriaxone for intramuscular administration**: 1 g ceftriaxone should be dissolved in 3.5ml of 1% Lidocaine Injection BP and given by deep IM injection. Last updated: Jan 2020	**First line** (GUM clinic): ceftriaxone I.M. 1 g STAT dose **and** oral metronidazole 400 mg BD for 14 days **and** doxycycline 100 mg BD for 14 days. **Second line**: oral metronidazole 400 mg BD for 14 days **and** ofloxacin 400 mg BD for 14 days. **Alternative second line**: moxifloxacin alone 400 mg OD for 14 days. ***M.genitalium* PID**: moxifloxacin 400 mg OD for 14 days.

Trichomoniasis

All patients: refer patients to GUM or local sexual health clinic for contact tracing and follow-up. Sexual partners should be treated simultaneously. **Laboratory diagnosis**: trichomonas culture, if transport is delayed, leave at room temperature. Do not refrigerate samples for culture. Delays over 24 hours are undesirable for culture. Last updated: Jan 2020	**First line**: oral metronidazole 400 mg BD for 7 days or 2 g * STAT dose (more adverse effects). * Avoid high dose metronidazole in pregnancy. **In pregnancy**: *if metronidazole refused consider for symptom control*, clotrimazole 100 mg pessary at night for 6 nights (without applicator).