West of Scotland Guideline *Approved June 2025*

BACTERIAL VAGINOSIS

What's New

A recent Australian study suggested partner treatment may be advised for recurrent BV. This should be specialist initiation only

Bacterial Vaginosis is the most common microbiological cause of abnormal vaginal discharge.
It is caused by an overgrowth of anaerobic organisms.

Clinical features

- Thin, offensive smelling vaginal discharge
- Vaginal odour
- Frequently recurs

NB: Not typically associated with itch, soreness or irritation

Signs

- Thin, white homogenous discharge coating introitus and vaginal walls, it may look slightly frothy. A characteristic odour is often noted

NB: vulval inflammation is not typical in BV

Diagnosis

In genitourinary settings two approaches to the diagnosis of BV are widely used: Amsel's criteria and the Hay/Ison criteria [1.] Both require microscopy to be available, which is not always the case in sexual health clinics. Where available, microscopy can be used, but syndromic management is supported by national guidelines [1,2]

The Hay/Ison criteria (used in the NaSH microscopy page) are:
Grade 0 no bacteria seen
Grade 1 (Normal): Lactobacillus morphotypes predominate
Grade 2 (Intermediate): Mixed flora with some Lactobacilli present, but Gardnerella or Mobiluncus morphotypes also present
Grade 3 (BV): Predominantly Gardnerella and/or Mobiluncus morphotypes. Few or absent Lactobacilli.
Grade 4 Gram positive cocci predominate (consider aerobic vaginitis)

Amsel's criteria are at least three out of:
(1) Thin, white, homogeneous discharge
(2) Clue cells on microscopy of wet mount
(3) pH of vaginal fluid >4.5
(4) Release of a fishy odour on adding alkali (10% KOH).

History

Diagnosis can be made on the basis of

- history of offensive, non-itchy discharge
- absence of pelvic/vulval pain and abnormal bleeding

- patient is not pregnant, post-partum or post-gynaecological instrumentation
- Vaginal pH >4.5

It is important to take a sexual history to consider the risk of STI and offer STI testing as appropriate as Chlamydia and Gonorrhoea can co-exist. A cervical screening history should be taken as cervical cancer is a differential diagnosis of a smelly discharge. Also consider if a tampon could have been retained.

Examination

If possible undertake vulval and speculum examination to visualise any discharge. Inspect the cervix to exclude any abnormality as a cause of offensive discharge.

Tests options

- Vaginal pH: collect a specimen of the discharge from the vaginal walls with a loop or swab and apply to narrow gauge pH 4-7 testing strip paper. Normal vaginal pH is <4.5 and a pH above this is seen in BV. NB: Semen, blood and some lubricants are also alkaline. Narrow range pH paper (ph 4.0-7.0) can be purchased from https://www.fishersci.co.uk/shop/products/ph-paper-4/10539641
- *If available – Microscopy*

  1. Wet mount to look for clue cells
  2. Gram stained slide from vaginal wall. BV suggested if: absent or reduced lactobacilli; predominance of gardnerella/mobiluncus morphotypes
  (Hay/Ison grade 3)[1]

N.B. Slides can be air dried and sent to the lab for staining and microscopy. Check local arrangements

High vaginal swabs are of limited value in diagnosing BV as organisms such as gardnerella can be present in 30-40% asymptomatic people. A culture reported as normal does not exclude clinical BV. Microscopy and vaginal pH are far more useful.

Management

Asymptomatic people do not need treatment (asymptomatic people should not be being diagnosed as without symptoms there is no indication to take a test).

General advice

The best ways of preventing BV are not know but avoiding anything that upsets the natural balance of bacteria in the vagina may help. This includes avoiding:

- Douching
- Frequent washing or bathing
- Bubble baths, scented soaps, antiseptics such as Dettol and feminine washes

Use of emollients as a soap substitute for the genital area (available from any pharmacy) is recommended.

BV is more common in people with an IUCD[5]
If recurrent episodes of BV are experienced alternative methods can be discussed.

Empirical treatment after a clinical diagnosis of BV is acceptable provided symptoms did not develop after:

- a gynae procedure
- birth, miscarriage or termination of pregnancy
  In these cases seek senior advice

Medication

1st line

Metronidazole 400mg oral twice daily 5-7 days (slightly lower relapse rate)

1st line in pregnancy

OR

Metronidazole 2g single oral dose (not recommended in pregnancy)

- Other 1st line options intravaginal metronidazole gel (0.75%) per vagina once daily for 5 days OR intravaginal clindamycin 2% cream per vagina once daily for 7 days (nb these vaginal preparations weaken condoms, clindamycin also has a risk of pseudomembranous colitis) These are significantly more expensive than oral metronidazole
- Advise patients to avoid alcohol during and for 48 hours after any metronidazole treatment due to the combination being likely to cause nausea and vomiting, tachycardia, hot flushes and palpitations

2nd Line

Clindamycin 300mg oral twice daily 7 days (risk of pseudomembranous colitis)

Or

Dequalinium chloride 10mg vaginal tabletsOne 10mg vaginal tablet daily for six days[6]

Insufficient evidence to assess effectiveness but anecdotally useful

Licensed indications:

Treatment of BV in adults

Relactagel® : 5 mL(1 tube) to vagina nightly for 7 nights

Relactagel® is unsuitable for people with an allergy to shellfish as the glycogen is derived from oysters. There may be a potential risk to a partner who is allergic to shellfish if these have been used.

Balance Activ® is not licenced for treatment

BV and Pregnancy

Refer to WOS Pregnancy and STI's Guideline

Follow up

Non–pregnant : Not necessary unless symptomatic
Pregnant : test of cure after a month[1]

Partner notification

No evidence of benefit in studies of screening and treating male partners in episodic BV
No studies of treatment in female partners in same sex couples although high incidence in female partners of females with BV: if a female partner is asymptomatic treatment need not be offered routinely.

Symptoms Persist Despite Treatment (i.e. client reports no response)

Consider alternative diagnosis
Check compliance with treatment
Try alternative therapy option - longer course of metronidazole may be more effective than single dose

Sporadic Recurrences

Up to 30% of people have a recurrence within 3 months

Examination and investigation should be considered but may not be necessary if a previous episode of the signs and symptoms of BV responded to antibiotic treatment, and there are no grounds to suspect an STI or cervical abnormality.

Frequent Recurrences of Bacterial Vaginosis

This is widely defined as more than four recurrences per year.

Speculum examination should be carried out. The diagnosis should be confirmed with microscopy +/- HVS.

A negative dry slide and persistent symptoms should prompt referral to a sexual health clinic with microscopy available.

Persistent, symptomatic BV may be associated with the presence of an IUD and an alternative method of contraception may need to be considered if there is no response to therapy.

Suppressive/preventive treatment

400mg metronidazole oral twice daily for 3 days at start and/or end of menstruation

Or

5g 0.75% metronidazole gel intravaginally twice weekly for 16 weeks[1]

Or

Relactagel®: 5 mL (1 tube) nightly to vagina for 2–3 nights after menstruation[5]

or

Balance Activ RX gel® 5 mL (1 tube) to vagina 1–2 times a week

A recent small open label randomised study(5) suggested in recurrent Bacterial Vaginosis concurrent treatment of cis-male partners of (cis- women with recurrent BV) with metronidazole 400-mg tablets and 2% clindamycin cream applied to penile skin (both twice daily for 7 days) reduced recurrence within 12 weeks. This should only be initiated by a specialist in GUM

References

1. Clinical effectiveness Group BASHH. UK guideline for the management of Bacterial Vaginosis 2012 https://www.bashhguidelines.org/media/1041/bv-2012.pdf accessed 30/05/2025
2. NHS Clinical Knowledge Summaries, Bacterial Vaginosis last revised July 2023, accessed 30/05/2025
3. Bacterial vaginosis | Health topics A to Z | CKS | NICE accessed 14/05/2021 https://www.scottishmedicines.org.uk/SMC_Advice/Advice/1194_16_dequalinium_Fluomizin/dequalinium_Fluomizin accessed 30/05/2025
4. Sherrard, J., Wilson, J. and Donders G. et al. (2018) 2018 European (IUSTI/WHO) guideline on the management of vaginal discharge. http://www.iusti.org accessed 30/05/2025
5. Vodstrcil et al, Male-Partner Treatment to Prevent Recurrence of Bacterial Vaginosis N ENGL J MED 2025;392:947-957 https://www.nejm.org/doi/full/10.1056/NEJMoa2405404
6. Fluomozin. Ge pH paper. Summary of Product Characteristics https://www.medicines.org.uk/emc/product/1997/smpc

Secondary care prices from GGC June 2025 where available

NB local contracts may result in different prices

Metronidazole 2g	**£1**
Metronidazole 400mg b.d. 7 days	**£3**
Metronidazole gel	**£5.50**
Clindamycin 2% Cream	**£14**
Clindamycin 300mg b.d. 7 days	**£5**
Relactagel 7 x 5ml tubes	**£ 14 (high street price)**
Balance Activ 7 x 5ml tubes	**£ 14.50 (high street price)**
Delquinium Chloride(Fluomizin)	**£9**

Patient information available at

https://www.nhsinform.scot/illnesses-and-conditions/sexual-and-reproductive/bacterial-vaginosis/

https://www.bashh.org/resources/46/bacterial_vaginosis_bv