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Uncommon Vaginitis Cases: Expect the Unexpected

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ABSTRACT

Most vaginitis cases are associated with candidiasis, bacterial vaginosis, or trichomoniasis. In clinical practice, however, clinicians occasionally encounter more unusual cases of vaginitis. In this report we present the history, clinical findings, and treatment plan for 5 uncommon cases of vaginitis.

Keywords: vaginal microscopy, vaginitis

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UNCOMMON VAGINITIS CASES: EXPECT THE UNEXPECTED

Vaginitis encompasses conditions that cause vaginal and vulvar itching, burning, irritation, and abnormal discharge, and can affect females across the age spectrum. Vaginitis can impact a woman's ability to attend school or work, limit sexual functioning, or harm her self-image.[1] Vaginitis symptoms affect most women at some point in their life.[2] Not surprisingly, vaginitis is one of the most common complaints at gynecology office evaluations.[3]

The majority of vaginitis cases are associated with candidiasis, bacterial vaginosis, or trichomoniasis.[4] Using history, pelvic examination, vaginal wet mount microscopy, and the potassium hydroxide whiff test, clinicians can diagnose these conditions with a fair degree of accuracy.[5] However, in their daily practice, clinicians may occasionally encounter more unusual cases of vaginitis, and will be faced with the challenge of recognizing a "zebra" as opposed to the "horses" that make up the bulk of cases.

This article presents 5 unusual cases of vaginitis, each illustrating the importance of comprehensive evaluation to arrive at the correct diagnosis and treatment plan. In each of these cases, a detailed history, complete pelvic exam, and microscopy were key to identifying the underlying cause of the patient's vaginitis symptoms.

CASE 1

A 23-year-old woman presents with a week-long history of vaginal odor and slight discharge. She says she can detect a foul smell all the time. She has recently been tested for sexually transmitted infections and she is in a monogamous relationship. The speculum exam is normal. There is no erythema or abnormal-looking discharge. The odor the patient mentioned is evident. Vaginal pH is elevated at 5.0 and microscopy is positive for moderate leukocytes. A careful bimanual examination reveals a septate vagina, with a tampon retained in the side of the vagina that was not examined via the speculum. Although the young woman had had several pelvic exams in the past, no examiner has ever noticed her longitudinal septum, and the patient had no prior knowledge of her anatomic anomaly.

A retained foreign body in the vagina such as a forgotten tampon, sex toy, or piece of a broken condom, can cause various vaginitis symptoms, including discharge, odor, and spotting. A retained foreign object therefore should be considered in the differential diagnosis for women seeking care for vaginitis complaints.[6] Although vaginal odor as the presenting symptom is often associated with bacterial vaginosis, a retained foreign body can also produce a strong malodor, and should prompt the clinician to examine the vaginal cavity thoroughly.

A speculum examination will usually reveal the foreign body. However, in rare cases, the foreign body can be missed if it lies above or below the speculum blade, if there is copious blood present, if vaginal tone is poor and the fornices are hidden, or, as in this case, if the woman has unusual anatomy. Palpation of the vaginal cavity, including the fornices, can help the clinician to detect vaginitis related to a foreign body. Ring forceps may be needed to remove the object, and immediate immersion of the object

into a waiting cup of water can help control the malodor in the exam room.

Bacterial vaginosis is commonly associated with a retained foreign body, and antibiotic therapy may be needed to relieve symptoms after removal. Toxic shock syndrome is a rare complication, and should be suspected if the patient also presents with generalized illness, fever, and rash.[7]

Of note, the presence of a vaginal septum may be indicative of other congenital anomalies of the urogenital system, and the patient should be offered a work-up that includes imaging.[8] In this case, the patient was subsequently diagnosed with a didelphic (double) uterus and 2 cervices.

CASE 2

A 32-year-old woman presents with a 1-month-long history of dyspareunia, discharge, and vaginal irritation. She has self-treated with an over-the-counter antifungal cream with no relief. The speculum exam reveals erythematous vaginal walls coated in yellow exudate. The pH is 5.5, the whiff test is negative, and the wet mount shows leukocytes too numerous to count, many immature epithelial cells (round cells with large nuclei), no yeast, no clue cells, and no trichomonads. These findings are consistent with desquamative inflammatory vaginitis (DIV). She is treated with a 2-week course of intravaginal 2% clindamycin cream, her symptoms resolve, and her follow-up exam is completely normal.

DIV is an uncommon and poorly understood form of vaginitis of unknown etiology. The condition is marked by severe vaginal inflammation and dyspareunia. On exam, the vaginal walls are coated in exudate. The vulva may also be sore and inflamed. The pH is elevated and microscopy typically reveals a large number of leukocytes and a preponderance of immature epithelial cells. DIV can mimic trichomoniasis, so trichomonas must be ruled out to make the diagnosis. Other conditions that must be ruled out include atrophic vaginitis and rare dermatoses that can affect the genital mucosa, such as linear immunoglobulin A disease, pemphigus vulgarus, mucous membrane pemphigoid, and erosive lichen planus. The absence of oral or ocular signs and symptoms helps differentiate DIV from these dermatoses.[9]

Although DIV may occur as an acute condition, for most women the problem is chronic and will require long-term management to control symptoms.[10] Although there are no controlled studies assessing the optimal treatment of DIV, the 2 main therapeutic regimens that have been used are 2 to 4 weeks of nightly intravaginal clindamycin (cream or suppositories) and/or 2 to 4 weeks of nightly intravaginal hydrocortisone (compounded cream or suppositories). Intravaginal estrogen has been used as an adjunct therapy.[9] Because relapse is common after initial treatment, many clinicians continue these regimens at lower doses for maintenance treatment.[11]

Most patients suffer symptoms of DIV for months before a diagnosis is made, with a commensurate effect on quality of life.[11] Even if clinicians who suspect DIV decide it best to refer to a specialist for management, at the very least they will recognize that they are dealing with a "zebra," and will not waste time on treatments that are unlikely to work.

CASE 3

A 16-year-old girl presents with a 2-week history of vaginal discharge and irritation. She indicates that she has never had intercourse or any sexual contact. She reluctantly agrees to a pelvic exam. Vaginal examination reveals a greenish discharge and a strawberry cervix. Vaginal pH is 5.0 and the wet mount reveals motile trichomonads and numerous leukocytes. Her symptoms resolve completely after a single dose of 2 grams of oral metronidazole.

Trichomoniasis is considered a sexually transmitted infection, but nonsexual transmission is theoretically possible.[12] Studies have shown that trichomonas can survive outside the human body for up to 30 minutes in fresh water, up to 1 hour on toilet seats, and up to 3 hours on wet clothes.[13] The literature contains a few reports of nonsexual transmission of trichomonas in tropical settings with poor hygiene.[14–16] In this case, it is possible that the patient was infected via a wet washcloth or other fomite.

Because it is far more likely for trichomoniasis to be transmitted through sexual contact than nonsexually, the patient (Case 3) should be gently questioned again about her sexual history, including sexual coercion and abuse. The clinician may find that the patient is in need of screening for other sexually transmitted infections, contraception, and counseling or other referrals.

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