

Revisiting group B strep (GBS) symptomatic vaginitis (GBSSV)

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Background

GBS-mediated vaginitis is uncommonly recognized and also uncommonly treated effectively.

Objective

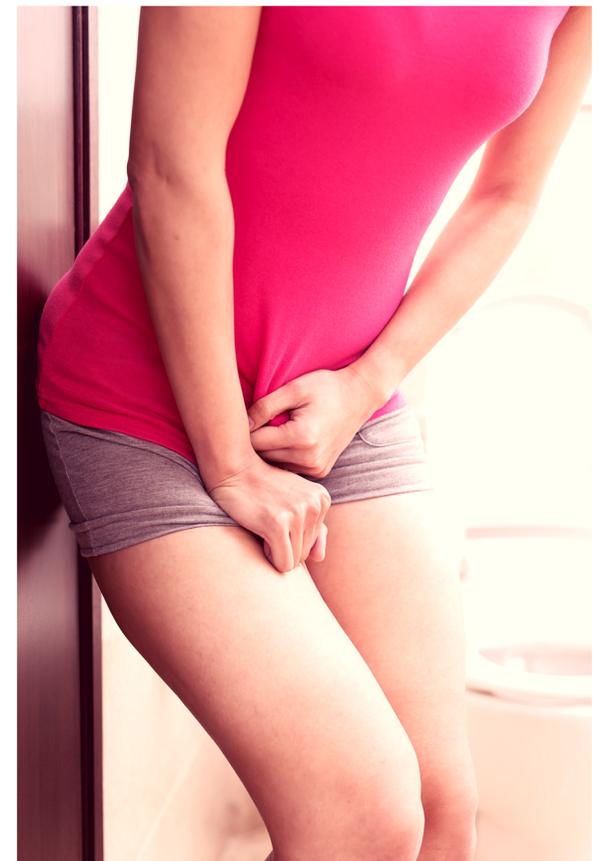
Construct a logic model of GBS vaginitis to inform practitioners and patients regarding epidemiology, presentation, diagnosis and treatment and opportunities for research and improved practice.

Methods

We performed a computerized literature search using available databases (Google, PubMed, Medline) to formulate an analysis and logic model matrix.

Results

- 1) There were only five sufficiently relevant articles and none utilized molecular microbiologic techniques.
- 2) GI and/or vaginal GBS colonization is noted in at least 15% of pregnant and non-pregnant women. Evidence of sexual transmission is inconsistent.
- 3) Signs (vulvar erythema, purulent discharge and crusting, scaling) and symptoms (irritation, burning, purulent discharge) are not adequately characterized.
- 4) Microscopic (saline prep) often demonstrates back to back white blood cells and prominence of paravaginal cells. Molecular microbiologic examination was not done.
- 5) Alternative nomenclature: Aerobic vaginitis (AV), desquamative vaginitis (DV) are common non-specific vaginitis are common terms for GBS vaginitis.
- 6) Treatment studies are inconclusive but commonly empirically recommend ampicillin, clindamycin vaginal cream 2% (CVC) as well as providine or chlorhexidine douches.
- 7) In one study, heavy GBS colonization was associated with vaginitis (E Honig).
- 8) In another study, heavy GBS colonization was associated with a significant risk of delivering a preterm infant who had a low birth weight (JA Regan).



"On 11/27/2012, my whole life changed. My son was born sleeping due to group B strep. A month prior to his death, I had gone to the ER complaining of clear fluid leakage. The nurse ran a swab test and told me I was clear and that I had an infection and she would get the doctor. About 30 minutes later she came in and told me to go buy yeast infection medication over the counter and that I had a yeast infection. I told her that I had no symptoms of a yeast infection. I was never seen by a doctor nor did the nurse run a culture to make sure it was a yeast infection."

-Gaby

Conclusion

GBS colonization is uncommonly recognized as a specific cause of symptomatic vaginitis. Informing pregnant women to see their health care provider promptly for appropriate treatment when they experience vaginitis symptoms may reduce their risk of giving birth preterm. Much clinical and applied microbiologically informed research is required to 1) better characterize this condition, 2) improve clinical care, and 3) study any association with GBS-caused miscarriages and stillbirths.

"Fortunately Bobbi had already been cultured during her 24th week of pregnancy due to an unusual vaginal discharge. Since her GBS culture was positive, she was put on oral antibiotics once the results were back. However, at 26 weeks, Group B strep caused Bobbi to go into preterm labor. Her daughter, Carissa, was born weighing only 1 pound, 12 ounces. Carissa was immediately put on antibiotics, but had to stay in the NICU for 75 days. Due to the effects of GBS and stress on her own body, Bobbi had to stay in the SICU and could not even see her tiny newborn daughter for the first three days."