

A Profile of Vaginal Discharge

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Abstract

A study of vaginal discharge was carried out in 2000 cases with limited facility and simple method in the private clinic. The age group included 16 to 45 years of age, incidence of trichomonal infection was found to be 21.55% and Monilia infection to be only 0.8%. There is a scope for further study of the Trichomonal infection in relation to other venereal diseases and abnormal cervical smear in Nepalese women,

Vaginal discharge consists of cervical discharge, exfoliated epithelium of the vagina, erythrocytes, a small number of leucocytes, nonpathogenic normal bacteria and yeast cells. The normal Ph of vagina is 4.3 to 5.2 Doderlein bacilli convert the glycogen in the epithelial cells to lactic acid maintaining a normal level of acidity in the reproductive age due to the presence of oestrogen. In the case of altered Ph due to glycogen imbalance, some normal inhabitants of the vagina become pathogenic organisms. Pinworms vaginal cosmetics, tight nylon underwears or foreign bodies may alter the normal physiology of the vagina. Drugs including "Pill", and douching also alter it. Poor hygiene the use of detergents and soap and operative procedures such as 'repair' conisation and cauterisation of the cervix also lead to a change of the Ph of the vagina.

Vaginal discharge can be physiological or pathological. It may be classified as purulent or nonpurulent. Nonpurulent may be copious due to hormones or candidiasis

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which is thin whitish and does not contain excessive pus. Purulent discharge may be due to Trichomonal or pyogenic infections which are pathological.

Physiologically, the excessive vaginal discharge may occur during the premenstrual period, during ovulation due to excessive cervical mucous, postcoitally and during pregnancy due to the hyperplasia and hypertrophy of vaginal epithelium. Pathological changes leading to vaginitis (inflammation of the vagina) may be caused by anything that causes a disturbance of the normal flora of the vaginal epithelium or the normal protective mechanism of the vagina. Vaginitis can be bacterial or viral, parasitic, allergic or due to mechanical irritation or functional (psychosomatic or psychosexual).

In Nepal, the woman who has got complaints relating to the private part prefers to consult a lady doctor in the private clinic.

In this article, the study of vaginal discharge is presented. The aim of the study is to observe the presentation and pattern of the problem with the limited facilities available. There is no facility for culture by use of Nickerson's medium in Nepal. A total of 2000 cases included in this study.

The patients present in the private clinic mostly middle class and dwelt in the urban area (75%). The study group age ranged from 16 to 45 years of age. Eightyfour percent were married and staying with the husband, 9% were unmarried and the rest stayed separate from the husband though they were married. 75% of the women had 0-3 children, 15% had 4-6 children and the rest 10% had more than 6 children. The patients' husbands' professions were mostly service holders in the Government or private sectors. Some of them worked as businessmen and some were agriculturists & politicians.

A vaginal swab was taken from those patients who presented with two or more of the following complaints or findings:

1. Excessive vaginal discharge disturbing to the patient.
2. Itching vulva or irritation in the vulva or vagina.
3. Burning micturition or a burning sensation after voiding.
4. Heaviness of the lower abdomen and backache.
5. Difficulty during or burning after intercourse.
6. Clinically suspected infection of foul smell during speculum examination (patient not aware of it).

Material & Method

A Cusco's speculum of appropriate size was inserted into the vagina after inspection of the vulva, urethra and vaginal orifice. The vagina and cervix were examined for any pathological changes such as inflammation erosion, polyps, cysts etc. The nature of the discharge was inspected. If the patient was bleeding vaginally, the test was postponed until she stopped bleeding. With a sterile cotton swab on a stick soaked in warm sterile water a specimen of discharge was taken from the cervix or the fornices. The microscopic examination of the specimen was undertaken in isotonic saline within five minutes. Motile flagellate protozoa could easily be seen with their jerky movements, candida, puscells or epithelial cells were also looked for. Gynaecological examination was completed to exclude other abnormalities.

Result

Total cases studied:	2000.
Positive for Trichomons Vaginalis (T. V.)	- 431 (21.55%)
Positive for Candida	- 16 (0.80%)

Age group-

16-20	21-25	26-30	31-35	36-45 or above
T. V. 48	T. V. 118	T. V. 129	T. V. 58	T. V. 78
Candida 1	Candida 9	Candida 3	Candida 3	Candida 0

Treatment

The treatment given was Metronidazole 200 mgm three times a day for both husband and wife. Some of the spouses did not take the medicine and some took it only after explaining them. There was a relapse of Trichomonal infection when the spouse did not take the medicine prescribed. Such patients were given another course of treatment after four weeks and suitable explanation. The patients were advised not to take alcohol during the course of treatment. For monilial infection, local therapy was prescribed for three weeks with Nystatin vaginal pessaries for 3 weeks. For those who did not wish for local treatment, oral Nystatin (500,000 i. u.) was given orally for ten days and antibiotics avoided as far as possible. The patients who had plenty of puscells without other abnormalities were given a course of antibiotics after culture and sensitivity test of the high vaginal swab and Triple Sulfa Cream locally for three weeks.

Betnovate cream externally was prescribed for pruritis together with advice not to use soap detergent or nylon panties. Anxious patients with copious normal vaginal discharge were re-assured and low dose tranquilisers for a couple of weeks.

Discussion

The incidence of Trichomonal infection has been found to be 21.55% in this study. In one report of 5742 cases in the U. S. A. 24.6% smears were positive for T. V. Candida found to be about 10% of non-pregnant woman but in this study it was shown to be only 0.80%. The importance of Protozoal infection in genital tract is significant in the sense that the association of T. vaginalis infection is an established cause of the abnormal smears but the cervical smear is not taken in this study. The association of the T. V. and cervical cancer as Moghissi et al (1968) found much higher frequency of gonorrhoea, syphilis and T. V. in the study groups for carcinoma of the cervix as compared with the normal population. There is a scope for further study these aspects in Nepal.

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