**University of the Philippines - Manila**

**Philippine General Hospital**

**OBGYN 251: Integrated Clerkship II in Obstetrics and Gynecology**

Case Protocol: Vaginitis

**Learning Objectives:**

1. To present the history and physical examination findings of a patient with Vaginitis
2. To formulate a working impression on the given history and physical examination
3. To read and interpret laboratory and diagnostic findings
4. To discuss the importance of the laboratory tests
5. To define Vaginitis
6. To discuss the signs, symptoms, and effects of Vaginitis
7. To provide an appropriate plan of management for the patient

**General Data:**

F.T. 18 year old, nulligravid, Roman Catholic, single from Paco, Manila

**Chief Complaint:**

Yellow vaginal discharge

**Past Medical History:**

She has no known allergies to food and medications

Currently taking Cyproterone acetate + ethinyl estradiol OCP since 2017 for contraception

**Family Medical History:**

(+) Hypertension - mother

(-) Diabetes mellitus, bronchial asthma, allergies, thyroid/blood/kidney disorders, cancer

**Personal and Social History:**

College graduate

Diet primarily consists of pork, vegetables, and rice

Smoker for 2 pack years, and occasional alcoholic drinker, denies illicit drug use

**Menstrual History:**

She had her menarche at 9 years old. Her menses are in regular intervals of 28-30 days, lasting for 4 - 5 days, with approximately 3-4 pads per day. She has no dysmenorrhea.

She was sure of her last menstrual period which she claimed was last **September 23, 2020.** Her past menstrual period was last August 24, 2020.

**Sexual History:**

First coitus at 16 years old

>10 sexual partner, allegedly promiscuous, who does not practice safe sex, no barrier method (e.g. condoms) was used. Currently, she has a sexual partner of 6 months which was noted to be promiscuous. No note of penile discharge from partner. No condom use.

Currently taking Cyproterone acetate + ethinyl estradiol OCP since 2017, for contraception

(+) Orolabial Herpes Simplex, resolved, 2019, given Acyclovir 400mg/tab TID for 7 days

**Obstetric History:**

Obstetric Score: G0

**History of Present Illness:**

9 months prior to consult, noted yellowish cottage cheese-like, non-foul smelling vaginal discharge, with associated vaginal pruritus, with no erythema, consulted PGH OBGYN OPD and was given Miconazole 1200mg/suppository 1 supp/day for 7 days with noted decrease of the yellowish vaginal discharge, now only seen as streaks in the underwear, and decreased intensity of vaginal pruritus.

On the interim, there is increase in episodes of yellowish vaginal discharge, foul smelling, with associated vaginal pruritus. There was no dyspareunia, no dysuria, and no changes in sexual habits. No medications, and consults done.

1 week prior to consult there is increasing in severity of the yellowish vaginal discharge, and vaginal pruritus, thus consulted at our institution

**Review of Systems:**

**General**: (-) fever, weakness, weight loss, pallor

**HEENT**: (-) headache, BOV, tinnitus, otalgia, dysphagia, dysphagia, colds, nausea, vomiting

**Pulmonary**: (-) dyspnea, cough

**CVD**: (-) chest pain, palpitations, easy fatigability, orthopnea, edema

**GI**: (-) constipation, dyschezia, diarrhea, jaundice, hematochezia, melena

**GU**: (-) dysuria, hematuria, urinary changes, urinary incontinence (-) postcoital bleeding

**Neurological**: (-) numbness, seizure, paresthesia, dizziness

**Endocrine:** (-) polydipsia, polyuria, polyphagia, change in heat/cold intolerance

**Physical Examination:**

**Vital Signs:** Temperature 36.7o C, blood pressure: 100/70, heart rate: 80 beats per minute, 98% O2 saturation, respiratory rate: 18 breaths per minute

**Height:**  150 cm **Weight:** 48.5kg **BMI:** 21.56

**General:** Patient is awake, conversant, and not in cardiorespiratory distress

**HEENT:** Anicteric sclerae, pink palpebral conjunctivae, (-) cervical lymphadenopathy, (-) neck vein engorgement, (-) anterior neck mass

**Heart and Lungs**: Adynamic precordium, distinct heart sounds, normal rate and regular rhythm, equal chest expansion, clear breath sounds

**Abdominal:** Soft abdomen, normoactive bowel sounds

**Extremities:** Full, equal, pulses, pink nail beds, CRT<2s, (-) cyanosis, (-) edema

***Pelvic/Internal Exam:***

**Speculum exam:** Papule like scars in the 9 o’clock to 12 o’clock position, vulvo-vaginal erythema, cervix is pink, smooth, no masses/lesions, no punctate hemorrhages seen on cervix and vagina, (+) “fishy” foul-smelling, curd-like whitish discharge which seems to be adherent to the vaginal walls

**Internal Exam:** Smooth, nulliparous vagina; cervix is 3x3cm smooth, small corpus, (-) adnexal masses, and tenderness, (-) cervical motion tenderness

**Rectovaginal Exam:** No perianal lesions, good sphincteric tone, intact rectal vault, no palpable masses, bilateral parametria smooth and pliable

**Diagnostics:**

8/13/2020 (Tondo Medical) Vaginal discharge CS: (+) yeast cells

1/22/2020

HbsAg: Non reactive

RPR: Non reactive

ICC ELISA: Non-reactive

**Assessment:**

Vulvovaginal candidiasis on top of bacterial vaginosis

Previous history of orolabial Herpes Simplex, resolved

Gravida 0

**Guide Questions:**

1. What are the pertinent points in the history and physical examination of the patient that led to the primary working impression?
2. Are there other points in the history and physical examination that you want to elicit?
3. Are there any significant laboratory/diagnostic test results? What is/are their significance? What other laboratory/diagnostic tests would you order for the patient?
4. What is Vaginitis? How is it diagnosed?
5. What are the signs and symptoms that you should look out for in a patient with Vaginitis?
6. What are the gynecologic and obstetrical effects of vaginitis to patients?
7. What complications should you watch out for vaginitis?
8. What is the complete diagnosis? How will you manage this patient? How will you monitor her response?