Antibiotics for treating bacterial vaginosis in pregnancy

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Treatment of bacterial vaginosis with oral antibiotics reduces preterm, prelabour rupture of membranes and the risk of having a low-birth-weight baby, but not the risk of preterm birth before 37 weeks of gestation. Since the above benefits are unlikely to improve neonatal well-being, in developing countries there may be no justification for implementing routine screening and treatment for bacterial vaginosis.

RHL Commentary by Thinkhamrop J

1. EVIDENCE SUMMARY

Bacterial vaginosis (BV) increases the risk of preterm birth and preterm prelabour rupture of the membranes from various evidence. This systematic review showed that treatment of bacterial vaginosis during pregnancy with oral antibiotics could reduce the overgrowth of bacteria but unlikely to reduce the risk of preterm prelabour rupture of membranes and birth before 37 weeks. However, treatment before 20 weeks’ gestation and of women with abnormal vaginal flora could reduce birth before 37 weeks.

Adequately designed randomized controlled trials were included and appropriate outcomes of interest have been analysed in the review.

2. RELEVANCE TO UNDER-RESOURCED SETTINGS

2.1. Magnitude of the problem

BV is relatively common. The reported prevalence in pregnant women ranges from 14% to 21% in Western countries (1, 2, 3, 4). In Asia, reported prevalence of BV during pregnancy is 13.6% in Japanese (5), 15.9% in Thai (5), and 18% in Indonesian women (6). BV prevalence is higher than that of other infectious diseases during pregnancy (such as asymptomatic bacteriuria, Neisseria gonorrhoea, Chlamydia trachomatis, and Trichomonas vaginalis) and there is evidence of an increased risk of preterm birth and preterm prelabour rupture of membranes among women who are carriers of BV. Theoretically, there is potential for the treatment of BV during pregnancy to reduce the preterm birth rate in a substantial proportion of women.

2.2. Applicability of the results

Overall, the results of the Cochrane Review would be applicable to developing country settings. Two of the fifteen included trials were conducted in developing countries (Indonesia, South Africa). Regardless of the route and type of antibiotic used, the conclusion of the review that routine screening and treatment of pregnant women for BV to prevent preterm birth should not be recommended at this stage.
2.3. Implementation of the intervention

There is no statistically or clinically significant effect of BV treatment on reduction of preterm births that take place before 37 weeks of gestation except in women with abnormal vaginal flora, and if treatment given before 20 weeks’ gestation. From the available evidence, there is no impact of the treatment on health outcomes. Although it is possible to have impact on health outcomes in high risk group as mentioned above that treatment could reduce birth less than 37 weeks, but need further information to confirm. Furthermore, as mentioned above, the diagnosis of BV during routine antenatal care units (ANC) is likely to be difficult to implement in developing countries because it requires trained personnel and resources. The current data are not support the use of BV screening and treatment as a strategy to reduce perinatal morbidity and mortality from preterm births.

3. RESEARCH

Large trials are needed to clarify whether screening and treatment of BV before 20 weeks’ gestation improves maternal and neonatal outcomes. Screening tests are another problem for diagnosing BV during pregnancy where further research is needed to find low-cost and easy-to-use tests.

References