

“SHOULD THE LENGTH OF TREATMENT FOR TRICHOMONIASIS IN WOMEN BE RECONSIDERED?”

PATRICK DUFF, MD (MARCH 2017)

Longer metronidazole treatment is better than 1-day dose for women with trichomoniasis

From 37 years of experience as a Women’s Healthcare Nurse Practitioner, I have found it is always better to prescribe metronidazole 500 mg bid for 7 days rather than 1-day treatment for women. I will prescribe 1-day treatment for men. I have been treating men and women using these regimens in a sexually transmitted diseases clinic for nearly 5 years. Colleagues have used the 1-time dose for women and it rarely works as well as the 7-day dose. However, I am always concerned about men taking the medication for 7 days, because often they are not symptomatic and they may stop taking their medication early if given the 1-week regimen, so I usually prescribe the 1-day dose for men. I wish more prescribers would offer treatment for the male partners, as they may not be symptomatic or may not want to spend the money to visit a provider. In my state, it is legal to prescribe for the partner without seeing him, and the Centers for Disease Control and Prevention suggests doing so. We encourage the men to come in but if the partner says he is unlikely to, we will treat without seeing him.

Carol Glascock, WHNP-BC
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>> Dr. Duff responds

I appreciate Ms. Glascock’s thoughtful comments. I am pleased that her years of clinical experience support the main conclusion reached by Howe and Kissinger that, in general, patients do better when they receive multidose therapy for trichomonas infection.¹ I

agree with Ms. Glascock’s observation that single-dose therapy still has a role in situations in which patients may not be adherent with multidose therapy, such as the asymptomatic male partner of an infected woman. I also agree wholeheartedly that women will have less likelihood of recurrence when their partner receives adequate antibiotic treatment. I concur that, in states where this practice is legally permissible, we should be willing to offer antibiotic therapy to the partner of our female patient.

Reference

1. Howe K, Kissinger PJ. Single-dose compared with multidose metronidazole for the treatment of trichomoniasis in women: a meta-analysis. *Sex Transm Dis.* 2017;44(1):29-24.

“IT IS TIME FOR HPV VACCINATION TO BE CONSIDERED PART OF ROUTINE PREVENTIVE HEALTH CARE”

BARBARA S. LEVY, MD (MARCH 2017)

Nurse practitioner urges advocacy for HPV vaccination

I could not agree more with Dr. Levy’s view on human papillomavirus (HPV) vaccination. I am a Doctor of Nursing Practice student and improving HPV vaccination rates in adolescents is the focus of my research project for the next year. Based on the current literature, the most significant factors for increasing vaccination rates are patient education and provider recommendation. As the article mentions, “special” attention should not be given to the HPV vaccine, because this raises questions with families presenting to the office for routine well-child care. There have been many missed opportunities for vaccination of our young people over the past 10 years. As a result, we will continue to see increases in HPV-related cancers. We have a vaccine that has the potential

to significantly decrease these cases, but it is underutilized. The recent recommendation of a 2-dose series (before the age of 15) should make completing the series easier. I urge all providers to be better advocates for their patients and make appropriate changes to their current practice in order to reduce the significant burden this disease carries.

Tiffany Edwards, MSN, APRN, FNP-BC
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“SHOULD YOU ADOPT THE PRACTICE OF VAGINAL CLEANSING WITH Povidone-Iodine Prior to Cesarean Delivery?”

ROBERT L. BARBIERI, MD
(EDITORIAL; JANUARY 2016)

“PREVENTING INFECTION AFTER CESAREAN DELIVERY: 5 MORE EVIDENCE-BASED MEASURES TO CONSIDER”

KATHRYN E. PATRICK, MD;
SARA L. DEATSMAN, MD; AND
PATRICK DUFF, MD (DECEMBER 2016)

Prepping the vagina before cesarean delivery

I enjoyed your review of the topic. I am interested in using vaginal preparation prior to cesarean in the settings of active-phase and second-stage arrest. This should be most valuable since we anticipate possible prolonged attempt at head delivery. There may be a need for head elevation as well. Of course, we have become enthusiastic about using reverse breech extraction in difficult cases since your article a few years ago. I have yet to do a Patwardhan maneuver. That seems to rely on rotating the spine anteriorly to get the second arm out. With the head impaction, there is limited range for neck rotation. With vaginal preparation, is there any concern about fetal exposure to iodine?

Kimberly Harney, MD
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» Dr. Barbieri responds

Dr. Harney raises the important issue of the potential adverse effects of povidone-iodine surgical preparation when used on a pregnant woman with ruptured membranes. There is very little direct evidence of a toxic effect of povidone-iodine on the fetus, but studies on women report that there is a transient increase in circulating iodine and iodine excretion following a vaginal povidone-iodine preparation.¹ The American College of Obstetricians and Gynecologists has suggested that chlorhexidine might be a superior vaginal disinfectant than povidone-iodine,² but chlorhexidine is not approved by the US Food and Drug Administration for use in the vagina, and many surgical nursing directors favor the use of povidone-iodine in the vagina.³

References

1. Velasco I, Naranjo S, Lopez-Pedreira C, Garriga MJ, Garcia-Fuentes E, Soriquer F. Use of povidone-iodine during the first trimester of pregnancy: a correct practice? *BJOG*. 2009;116(3):452-455.
2. Committee on Gynecologic Practice, American College of Obstetricians and Gynecologists. Committee Opinion No. 571: solutions for surgical preparation of the vagina. *Obstet Gynecol*. 2013;122(3):718-720.
3. Guideline for preoperative patient skin antisepsis. In: *Guidelines for perioperative practice*. Denver, CO: Association of Perioperative Registered Nurses, Inc; 2014.

“PREVENTING INFECTION AFTER CESAREAN DELIVERY: 5 MORE EVIDENCE-BASED MEASURES TO CONSIDER”

KATHRYN E. PATRICK, MD;
SARA L. DEATSMAN, MD; AND
PATRICK DUFF, MD (DECEMBER 2016)

Another way to prevent post-cesarean delivery infections

After 40 years in ObGyn practice (I am now retired), I find it interesting

that experts have ignored a major potential source of infection—the operation team. Back in the day of Phisohex (hexachlorophene) use, we scrubbed our hands, arms, and fingers for a finite time—10 minutes—systematically and religiously. Our infection rates increased only when house staff rather than surgical assistants “helped” us. When scrubbing, I was always amazed that the house staff appeared at the sink long after I did and left before I had completed my presurgical ritual. (This was not true of non-MD assistants.) And my private practice postoperative infection rate reflected the difference. So perhaps the evidence is skewed away from this source of infection, which I submit may well be the major one!

Steve Melkin, MD
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