CLINICAL GUIDELINE

Trichomoniasis Diagnosis

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Lead Author:	Kay McAllister
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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

TRICHOMONIASIS

DIAGNOSIS

Women

- When microscopy available:
  Wet mount preparation from posterior vaginal fornix (sensitivity 40-80%). We no longer screen women without symptoms for TV. This should be read ideally within 10 minutes of preparing the slide. Self-administered vaginal swabs are likely to give equivalent results and can be considered if the client declines to be examined
- Where microscopy is not available:
  The diagnosis may be made provisionally if there is profuse frothy discharge, vaginitis and a raised pH. A charcoal HVS should be collected for TV identification and sent to the local laboratory. (A self-taken vaginal swab will give equivalent results)
- Offer full sexual health screen
- See also vaginal discharge protocol

Men:

- In practice, treatment is usually epidemiological, without identification of the organism, which is difficult - highest yield is from centrifuged first catch urine deposit
- Urethral culture or culture of first-void urine will diagnose 60-80% cases, sampling both sites simultaneously will significantly increase the diagnostic rate using microscopy or culture. TV medium should be used for both samples and is available within Sandyford Central Lab (BASHH guidance 2014)
- Offer full sexual health screen

MANAGEMENT

Metronidazole 400mg BD for 7 days (95% response)

OR

Metronidazole 2g stat

Advise to avoid alcohol for the duration of treatment and for 48 hours afterwards with Metronidazole (72 hours for Tinidazole)

Avoid a 2g stat dose as above in pregnant women and if possible in breast feeding women. In breast feeding women discard breast milk for 24 hours if using Metronidazole (stat dose) and 72 hours if using Tinidazole

ALLERGY - There is no effective alternative to 5-nitroimidazole compounds and client with a true allergy should be discussed with a GUM consultant.

Clients should be advised to avoid sexual intercourse (including oral sex) until after follow-up.

PARTNER NOTIFICATION

- Discuss any complex issues with GUM DoD or SHA team
- All partners within the past 4 weeks should be screened for TV and treated epidemiologically, irrespective of their results (owing to low test sensitivity)
- Epidemiological treatment for partners is as above
- Partners should be offered a full sexual health screen

FOLLOW UP

- If treated epidemiologically and no other findings at first visit Client should be given a results card to call results line in one week for results
- At 2 weeks a SHA telephone consultant to check compliance, when they last had sex, and if asymptomatic
- Women: If still symptomatic, client will be facilitated to clinic for a test of cure with Microscopy or, if microscopy unavailable such as in Sandyford Connects , a repeat HVS should be taken (consider self-administered swabs)
- Male: If still symptomatic, perform urethral gram stain in case non-gonococcal urethritis coexists; and TV test of cure
- Completion of Partner Notification
- Final review at 3 months for repeat STS and HIV
- Check compliance with therapy and exclude vomiting of metronidazole.
- Repeat sexual history for possibility of re-infection and ask if partner(s) have been treated.

RECURRENT/RELAPSING TV

Non response to STANDARD therapy

Metronidazole – 400 mg BD for 7 days

Non response to second line therapy

Metronidazole 2g daily for 7 days

OR

Metronidazole 800mg TDS for 7 days

Advise to avoid alcohol for the duration of treatment and for 48 hours afterwards with Metronidazole (72 hours for Tinidazole)

Avoid a 2g stat dose as above in pregnant women and if possible in breast feeding women. In breast feeding women discard breast milk for 24 hours if using Metronidazole (stat dose) and 72 hours if using Tinidazole

- If a client fails third line therapy discuss with a consultant, before considering alternative options. Resistance testing should be considered.

TV and PREGNANCY

- There is increasing evidence that TV is associated with detrimental pregnancy outcomes such as pre-term labour and low birth weight though currently there is no evidence the association is causal.
- Pregnant women who are diagnosed with TV can be treated with oral metronidazole 400 mg bd for 7 days
- Avoid high dose stat doses of Metronidazole in pregnancy or breast-feeding. (Stat doses can be considered if the woman is able to discard milk for the next 12-24 hours after receiving the stat dose.)
- Meta-analyses have concluded that there is no evidence of teratogenicity from the use of metronidazole in women during the first trimester of Pregnancy. Tinidazole's safety in pregnant women has not been well-evaluated. The manufacturer states that the use of tinidazole in the first trimester is contraindicated

- Symptomatic women should be treated at diagnosis

REFERENCES

- BASHH UK National Guideline on the Management of Trichomonas vaginalis 2021 www.bashhguidelines.org/media/1310/tv-2021.pdf [accessed online March 2025]