SHC Treatment Recommendations for Vaginitis

Last updated: 11/2026

	Inpatient & Outpatient Options		Outpatient Only
	Preferred Agents	**Recurrent/Refractory VVC**	**Severe, Refractory VVC & Sexual Partners**
Bacterial Vaginosis (BV)	**Evaluate if treatment is indicated** [a] • Evaluate if treatment is indicated; treatment likely not indicated in asymptomatic patients. **Treatment Indicated:** [a] Metronidazole 500 mg po BID x7d	**First Choice:** Metronidazole vaginal gel 0.75 %, 1 applicatorful (5g) PV qHS x 5d **Second Choice:** Clindamycin vaginal cream 2 %, 1 applicatorful (5 g) PV qHS x7d **Alternative Options (off-label):** • Clindamycin 300 mg PO BID x 7d, or • Repeat metronidazole PO course	**Symptomatic & refractory to multiple preferred and refractory regimens (not pregnant):** • Boric acid vaginal capsules [d] ○ 600 mg PV qHS x3-4 weeks followed by metronidazole vaginal gel 0.75 % intravaginally BIW x4-6 months ○ See warnings below **BV Partner Treatment:** • Recommended concurrent male partner treatment in recurrent, symptomatic BV • Shared decision for same-sex partners • Shared decision w/ 1st symptomatic BV occurrence
***Candida* group** *C.albicans, tropicalis, parapsilosis, dubliniensis*	**Evaluate if treatment is indicated** [b] • Evaluate if treatment is indicated; treatment likely not indicated in asymptomatic patients. **Treatment Indicated:** [b] • Miconazole 2 % vaginal cream, 1 applicatorful (5g) PV qHS x 7 d, or • Clotrimazole 1 % vaginal cream, 1 applicatorful (5g) PV qHS x 7-14 days, • Fluconazole 150 mg PO x1 ○ Pregnancy: risk v. benefit, avoid in 1st trimester	**First Choice (off-label):** • Extend duration of vaginal azole **Second Choice (off-label):** • Fluconazole 150 mg po q 72h x 2 doses (Pregnancy: risk v. benefit, avoid in 1st trimester)	**Symptomatic & refractory to multiple preferred and refractory regimens**: • Nystatin intravaginal suppositories [e] ○ 100,000 units qHS x 14 days **Symptomatic & refractory to multiple prior preferred and refractory regimens (not pregnant):** • Boric acid: [d] ○ 600 mg capsules intravaginal qHS x2-3 weeks fb metronidazole vaginal gel 0.75 % intravaginally BIW x4-6 months ○ See warnings below • Ibrexafungerp: [f] ○ VVC: 300 mg PO BID x1 day (total dose 600 mg/ 4 x 150 mg tablets) ○ Recurrent VVC: 300 mg PO BID x1 day repeat monthly x 6 months ○ See warnings below • **Other potential options**: see below [g]
Candida glabrata / krusei	**Evaluate if treatment is indicated** [b] • Treatment is likely not indicated in asymptomatic patients; eradication of *C. glabrata/krusei* is challenging. **Treatment Indicated:** [b,c] • **First Choice:** ○ Terconazole 0.4 % vaginal cream, 1 applicatorful PV qHS x 7 d • **Second Choice:** ○ Miconazole 2 % vaginal cream, 1 applicatorful PV (5g) qHS x 14 d • **Third Choice:** ○ Fluconazole 150 mg PO q 72 h x 3 doses (Pregnancy: risk v. benefit, avoid in 1st trimester)	**Symptomatic & refractory to multiple prior preferred regimens (non-pregnant, off-label, limited data):** • Voriconazole [g] ○ 200 mg PO BID x 14d ○ See warnings below	
T. vaginalis	Metronidazole 500 mg po BID x7d		See: CDC: Trichomoniasis

PV: Per Vagina, intravaginal route. Intravaginal route may not be appropriate for pregnant patients with ruptured membranes (PPROM).

a. **Evaluate if treatment is indicated if BV targets detected.** Treatment is likely not indicated in asymptomatic patients. Patients for whom treatment may be indicated includes, but is not limited to: symptomatic BV, pregnant with threated preterm delivery, preterm premature rupture of membranes, immunocompromised status.

b. **Evaluate if treatment is indicated if *Candida* is detected**. Treatment is likely not indicated in asymptomatic patients. Patients for whom treatment may be indicated includes, but is not limited to: symptomatic VVC, pregnant with preterm premature rupture of membranes (PPROM), or immunocompromised status. **For *C. glabrata/ krusei*** specifically, CDC encourages providers to rule out other causes of vaginal symptoms prior to attempting treatment as eradication may be challenging and recommendations are based on low-level of evidence.

c. **Treatment recommendations are off-label/low level evidence**. *C. glabrata* has increased resistance to fluconazole and topical azole antifungals. Topical azoles may have some activity, but optimal treatment options and durations are not clearly guided.

d. **Boric Acid Vaginal Capsules** (off-label): Over-the counter, non-formulary for SHC inpatient, fatal if ingested orally, contraindicated in pregnancy, not to be used on broken skin, patients to abstain from sexual intercourse during treatment due to risk of partner skin irritation, may weaken effectiveness of condoms, to be kept out of reach of children and pets, avoid in patient with risk of suicide.

e. **Nystatin Vaginal Suppositories** are extemporaneously compounded and require specialty outpatient pharmacy; they are not formulary for SHC inpatient.

f. **Ibrexafungerp (Brexafemme)** non-formulary at SHC and is not currently available following a voluntary recall for potential cross-contamination and Scynexis transferred this drug to GSK late 2025. Currently, GSK lists Brexafemme as temporarily unavailable and there is no estimated date for this product to return to the market. contraindicated in pregnancy and requires effective contraception during treatment and through 4 days following last dose. Expensive.

g. **Other:** Gentian Violet 0.4% Vaginal Gel / vaginal painting may be available by specialty clinics and pharmacies. Osteseconazole (Vivoja) may be an option for patients who are not of childbearing potential (https://vivjoa.com/); several contraindications, likely requires prior authorization and specialty outpatient pharmacy.

h. **Voriconazole:** Not for pregnant women for management of VVC. Women of childbearing potential should use effective contraception during treatment. Use in breastfeeding has limited experience and safety for use in lactating women is unknown.

References:

1. CDC: Vulvovaginal Candidiasis - STI Treatment Guidelines
2. Committee on Practice Bulletins – Gynecology. ACOG Practice Bulletin No. 215: Vaginitis in Nonpregnant Patients. Obstetrics & Gynecology. 2020. 135(1):E1-17.
3. NIH Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Candidiasis (Mucocutaneous): Adult and Adolescent OIs | NIH; 2024. accessed 5/29/26.
4. Pappas PG, et al. Clinical Practice Guideline for the Management of Candidiasis: 2016 Update by the Infectious Diseases Society of America. Clinical Infectious Diseases. 2016. 62(4):409-17.
5. Fluconazole (Diflucan®) - MotherToBaby | Fact Sheets - NCBI Bookshelf; accessed 5/29/26.
6. UpToDate LexiDrug [Fluconazole] and Briggs: Fluconazole (Briggs Drugs in Pregnancy and Lactation) - UpToDate® Lexidrug™; accessed 5/29/26.
7. Sood G, et al. Terconazole cream for Non-Candida albicans Fungal Vaginitis: Results of a Retrospective Analysis. Infectious Diseases in Obstetrics and Gynecology. 2000. 8:240-243 doi: 10.1155/S1064744900000351
8. Corson SL, Kapikian RR, Nehring R. Terconazole and miconazole cream for treating vulvovaginal candidiasis, a comparison. Journal of Reproductive Medicine. 1991. 36(8)561-7.
9. Vieira-Baptista P, et al. International Society for the Study of Vulvovaginal Disease Recommendations for the Diagnosis and Treatment of Vaginitis. 2023. ISSVD recommendations for the diagnosis and treatment of vaginitis.pdf
10. BREXAFEMME (ibrexafungerp) [Package Insert]. SCYNEXIS. 2022.
11. Walley AH, et al. Ibrexafungerp: Mechanism of Action, Clinical, and Translational Science. Clinical and Translational Science, Open Access. 2025. 18(9): e70362.
12. Li T, et al. A randomized clinical trial of the efficacy and safety of terconazole vaginal suppository versus oral fluxonazole for treating severe vulvovaginal candidiasis. Medical Mycology. 2015. 53(5) https://doi.org/10.1093/mmy/myv017
13. Berkow E, Lockhart S. Fluconazole resistance in Candida species: a current perspective. Infection and Drug Resistance. 2017. 10: 237-245.
14. Sobel J. Candida vulvovaginitis in adults: Recurrent Infection. UpToDate. 2/2026. Accessed 5/29/26.
15. Phillips NA, et al. Topical treatment of recurrent vulvovaginal candidiasis: an expert consensus. Women's Health Reports. 2022. 3(1):38-42; doi: 10.1089/whr.2021.0065
16. CDC: Trichomoniasis - STI Treatment Guidelines
17. Vieira-Baptista P, et al. International Society for the Study of Vulvovaginal Disease Recommendations for the Diagnosis and Treatment of Vaginitis. 2023. ISSVD recommendations for the diagnosis and treatment of vaginitis.pdf
18. BREXAFEMME (ibrexafungerp) [Package Insert]. SCYNEXIS. 2022.
19. Walley AH, et al. Ibrexafungerp: Mechanism of Action, Clinical, and Translational Science. Clinical and Translational Science, Open Access. 2025. 18(9): e70362.
20. Li T, et al. A randomized clinical trial of the efficacy and safety of terconazole vaginal suppository versus oral fluxonazole for treating severe vulvovaginal candidiasis. Medical Mycology. 2015. 53(5) https://doi.org/10.1093/mmy/myv017
21. Berkow E, Lockhart S. Fluconazole resistance in Candida species: a current perspective. Infection and Drug Resistance.2017.10: 237-245.
22. Sobel J. Candida vulvovaginitis in adults: Recurrent Infection. UpToDate. 2/2026. Accessed 5/29/26.
23. Phillips NA, et al. Topical treatment of recurrent vulvovaginal candidiasis: an expert consensus. Women's Health Reports. 2022. 3(1):38-42; doi: 10.1089/whr.2021.0065
24. CDC: Trichomoniasis - STI Treatment Guidelines