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# Vaginitis diagnostic testing

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Policy contains: Bacterial vaginosis; vaginitis; vulvovaginal candidiasis; trichomoniasis.

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## Coverage policy

The following diagnostic tests for vaginitis, when provided in accordance with guideline-directed care, are clinically proven and, therefore, medically necessary for members who present with symptoms of vaginitis based on clinical examination and history (American College of Obstetricians and Gynecologists, 2020; Workowski, 2015):

- Point-of-care testing (i.e., pH testing, potassium hydroxide "whiff test," or saline microscopy) or Gram stain with Nugent scoring for bacterial vaginosis.
- Microscopy and, if necessary, vaginal yeast culture for *Candida* species.
- Nucleic acid amplification testing for the diagnosis of *Trichomonas vaginalis* infection.
- U.S. Food and Drug Administration-approved nucleic acid-based microbial testing when any of the above tests are unavailable or inconclusive and the test results will impact care management (Workowski, 2015). See approved list: <https://www.fda.gov/medical-devices/vitro-diagnostics/nucleic-acid-based-tests>.

Repeat testing for *Trichomonas vaginalis* is medically necessary within three months after treatment because of the high rates of infection recurrence (American College of Obstetricians and Gynecologists, 2020).

### Limitations

The following tests are investigational/not clinically proven and, therefore, not medically necessary for diagnosis of vaginitis (American College of Obstetricians and Gynecologists, 2020; Workowski, 2015):

- Papanicolaou testing. However, for incidental findings of vulvovaginal candidiasis, bacterial vaginosis, or trichomoniasis on a Papanicolaou test, diagnostic confirmation is medically necessary.
- Diagnostic testing that employs microarray or sequencing methods.
- Polymerase chain reaction testing for *Candida* species or bacterial vaginosis.

Routine screening for bacterial vaginosis in asymptomatic pregnant women for prevention of preterm delivery is investigational and, therefore, not medically necessary (Owens, 2020).

### Alternative covered services

In-network healthcare provider services for diagnosis and management of genital disorders.

## Background

Vaginal symptoms are one of the most common presentations of patients to obstetrician-gynecologists (American College of Obstetricians and Gynecologists, 2020). The most common causes of vaginitis include vulvovaginal candidiasis, bacterial vaginosis, and trichomoniasis. Less common etiologies include vulvar skin diseases, desquamative inflammatory vaginitis, and genitourinary syndrome of menopause. Bacterial vaginosis is associated with a high economic burden and marked racial disparities in prevalence (Peebles, 2019).

Vaginitis may have significant repercussions in terms of mental distress and physical discomfort, episodes of school or work absence, and sexual dysfunction (American College of Obstetricians and Gynecologists, 2020). Vaginitis is frequently seen in concert with sexually transmitted diseases, including human immunodeficiency virus. Distinguishing vaginal from vulvar symptoms is important to guide evaluation and treatment. Atrophic vaginitis is common with aging and the decreased ovarian production of estrogen. An accurate diagnosis of atrophic vaginitis among postmenopausal women is vitally important to choosing the appropriate treatment.

Diagnosis of vaginitis includes a clinical examination and history of perineal and vaginal discomfort, itching, or discharge, along with a choice of point-of-care testing, laboratory testing, and molecular (bacterial nucleic acid) diagnostic assays (Coleman, 2018). Point-of-care testing includes pH testing, a potassium hydroxide “whiff test” (amine odor test), and saline microscopy. The standard of care for determining the initial diagnosis relies on applying three of the four results from point-of-care testing to Amsel criteria:

- Homogeneous, thin, white discharge that smoothly coats the vaginal walls.
- Clue cells (e.g., vaginal epithelial cells studded with adherent coccobacilli) on microscopic examination.
- pH of vaginal fluid > 4.5.
- A fishy odor of vaginal discharge before or after addition of 10% potassium hydroxide.

Laboratory examination (e.g., Gram stain) might include a microscopic examination of the discharge or vaginal vault with culture for bacterial, fungal, and parasitic etiologies. Direct deoxyribonucleic acid probe and nucleic acid amplification assays are the primary commercial molecular assays available in the United States for diagnosing bacterial vaginitis. Microarray and sequencing technologies are emerging methods that are currently available for research purposes.

## Findings

A systematic review (Nwankwo, 2017) of syndrome diagnosis in the evaluation of vaginitis followed the World Health Organization algorithm and reported high sensitivity (91.5% to 100%) but moderate to low specificity (0% to 27.5%) among women with vaginal symptoms. The authors noted the method’s substantial potential for overtreatment and physician error.

A systematic review (n = 4,155 women) examined the association between genital tract infection and preterm birth (before 37 weeks' gestation) and the impact of screening for infections during pregnancy on premature birth rate (Sangkomkamhang, 2015). The rate of preterm birth before 37 weeks' gestation was significantly lower in the intervention group (3% versus 5% in the control group) with a risk ratio of 0.55 (95% confidence interval 0.41 to 0.75; moderate-quality evidence). There is also evidence that routine screening of pregnant women before 20 weeks' gestation for vaginal infection is associated with cost savings when used for the prevention of preterm birth.

The U.S. Preventive Services Task Force (2008) recommended not screening pregnant women for bacterial vaginosis who were at low risk for preterm delivery, and found insufficient evidence to assess the balance of benefits and harms of screening for bacterial vaginosis in pregnant women at high risk for preterm delivery.

In 2020, we included updated guidance from the Centers for Disease Control and Prevention (Workowski, 2015), the American College of Obstetricians and Gynecologists (2020), and the U.S. Preventive Services Task Force (Owens, 2020), along with a systematic review and meta-analysis (Kahwati, 2020) that informed the Task Force recommendations. There is uniform consensus among guidelines for testing recommendations in patients presenting with symptomatic vaginitis.

There is less consensus for testing asymptomatic populations. The Centers for Disease Control and Prevention (Workowski, 2015) recommends routine *Trichomonas vaginalis* screening in women with human immunodeficiency virus infection because of the adverse events associated with asymptomatic trichomoniasis and human immunodeficiency virus infection. Screening can be considered in high prevalence settings (e.g., sexually transmitted disease clinics or correctional facilities) or for persons at high risk for infection (e.g., persons with multiple sex partners, exchanging sex for payment, illicit drug use, or a history of sexually transmitted disease). However, in such instances there are insufficient data supporting a correlation between screening and treatment for asymptomatic trichomoniasis and a reduction in health and health disparities or reduced community burden of infection. Decisions about screening might be informed by local epidemiology of infection rates.

We added a list of commercially available nucleic acid-based tests approved for diagnosing an infection with pathogens causing bacterial vaginitis (U.S. Food and Drug Administration, 2020). We modified the coverage and limitations sections to include information on types of medically necessary testing for symptomatic populations, based on new evidence-based guidance from the American College of Obstetricians and Gynecologists (2020), as follows:

- For the initial evaluation of patients with vaginitis symptoms, a complete medical history, physical examination of the vulva and vagina, and point-of-care testing of vaginal discharge (i.e., pH testing, a potassium hydroxide whiff test, and microscopy) are recommended (Level C = recommendation based primarily on consensus and expert opinion).
- For the diagnosis of bacterial vaginosis, Amsel criteria based on clinical testing or Gram stain with Nugent scoring is recommended (Level A = recommendations based on good and consistent scientific evidence).
- For the diagnosis of trichomoniasis, nucleic acid amplification testing is recommended (Level A).
- Patients should be retested within three months after treatment for *Trichomonas vaginalis* because of the high rates of infection recurrence (Level B = recommendations based on limited or inconsistent scientific evidence).
- For diagnosis of vulvovaginal candidiasis, one of the following two findings is required:
  - Visualization of spores, pseudohyphae, or hyphae on wet-mount microscopy.
  - Vaginal fungal culture or commercial diagnostic test results positive for *Candida* species.
- Papanicolaou tests are not reliable for the diagnosis of vaginitis (Level B).
- Diagnostic confirmation is recommended for incidental findings of vulvovaginal candidiasis, bacterial vaginosis, or trichomoniasis on a Papanicolaou test (Level B).

## References

On July 9, 2021, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were "vaginitis," "vaginal discharge," and "vaginal infection." We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Sangkomkamhang US, Lumbiganon P, Prasertcharoensuk W, Laopaiboon M. Antenatal lower genital tract infection screening and treatment programs for preventing preterm delivery. *Cochrane Database Syst Rev*. 2015;(2):CD006178. Doi: 10.1002/14651858.CD006178.pub3.

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## Policy updates

7/2017: initial review date and clinical policy effective date: 9/2017

7/2018: Policy references updated. Policy ID changed.

8/2019: Policy references updated.

10/2020. Policy references updated. Coverage modified.

10/2021: Policy references updated