Treatment of trichomoniasis in females with and without gonorrhoea

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Summary
46 women with trichomoniasis and gonorrhoea were treated with nimorazole (300 mg twice daily for 7 days) and a trichomonal cure rate of 90.2 per cent. was noted.

In addition, 53 of 112 patients with trichomoniasis but without gonorrhoea, were treated with metronidazole (200 mg three times a day for 7 days) and 59 with nimorazole (300 mg twice daily for 7 days) in a randomized trial. The cure rates were 96 and 90.5 per cent. respectively. There was no significant difference in the results noted in the two groups.

Neither the trichomonal infection itself nor the result of antitrichomonal therapy was affected by antagonococcal therapy (one-day treatment with ampicillin or single-dose therapy with doxycycline).

No increase was noted in the frequency of candidiasis after antitrichomonal therapy (in patients without gonorrhoea) or after antitrichomonal therapy, but there was substantial variation between consecutive specimens in the prevalence of C. albicans.

Patients and methods
All women attending the clinic were examined at all visits for the presence of N. gonorrhoeae, T. vaginalis, and C. albicans during the period November, 1971, to October, 1972.

Diagnosis
N. gonorrhoeae was detected by direct microscopy and/or culture. Specimens were taken from the urethra, cervix, and rectum, and were cultured on Thayer-Martin medium. T. vaginalis was identified by direct microscopy and/or culture during the first half of the investigation, and by culture alone during the second half. Cultures were done by the method of Diamond (1957).

C. albicans was identified by culture on Sabouraud agar plates. Eriksson and Wanger (1975) have described the diagnostic procedures in detail.

Treatment
Patients with uncomplicated gonorrhoea were treated either with 2 g ampicillin (Doktacillin®, Astra Läkemedel AB, Sweden) administered orally in two doses with a 5-hour interval or with 0.3 g doxycycline (Vibramycin®, Pfizer AB, Sweden) in a single oral dose.

Patients with T. vaginalis were treated differently depending on the presence or absence of N. gonorrhoeae.

(a) Patients with trichomoniasis and gonorrhoea Trichomoniasis was treated with nimorazole 300 mg twice daily for 7 days. Every third patient was excluded from treatment.

(b) Patients with trichomoniasis alone These patients were treated in randomized series with metronidazole (Flagyl®, AB Leo, Sweden) 200 mg three times a day for 7 days or, alternatively, with nimorazole 300 mg twice daily for 7 days. The randomization was carried out in groups of ten patients, five being treated with metronidazole and five with nimorazole. The investigator did not know which preparation each patient received.

Treatment for trichomoniasis was not given until gonorrhoea was diagnosed or excluded. In patients in whom both gonorrhoea and trichomoniasis were diagnosed and treated at the same visit, antitrichomonal treatment was started the day after the antitrichomonal treatment.

Patients in whom trichomonal cultures became positive during the follow-up period, after antitrichomonal therapy, were not treated again.

All pregnant patients were excluded from the study, and it was not usually possible to treat the sexual partners.
of the patients with trichomonal infestation. Blood specimens were collected for white blood cell counts and liver function tests before and immediately after treatment.

*Patients with candidiasis*  Patients with candidiasis were not treated until other therapeutic procedures and follow-up examinations had been completed.

**Follow-up**

Patients were asked to return for follow-up examinations at weekly intervals. Our aim was to recall patients treated for trichomoniasis for at least three visits. At these visits the patients were asked about subjective symptoms and complaints, and any side-effects of the drugs.

**Results**

During the period of investigation specimens were collected from 1,347 women, and at the first visit *N. gonorrhoeae* was found in 506 cases (38 per cent.), *T. vaginalis* in 272 (20 per cent.), and *C. albicans* in 233 (17 per cent.).

The frequency of infection, the relationships of the different pathogens, and their symptomatical significance have already been reported (Eriksson and Wanger, 1975), as well as the results of the antitrichomonal treatment (Enfors and Eriksson, 1975).

*Patients with trichomoniasis and gonorrhoea*

In this group, 46 patients were treated with nimorazole (Table). Among the patients in whom antitrichomonal treatment failed, three were noted at the first follow-up visit and one at the second.

In 26 patients the gonorrhoea was treated with ampicillin and in twenty with doxycycline. Neither ampicillin nor doxycycline therapy affected the results of the antitrichomonal therapy, nor was any difference noted in the therapeutic results if the antitrichomonal therapy was initiated at the same time as the antitrichomonal therapy or later.

*Patients with trichomoniasis alone*

In this group, 112 patients were treated—53 with metronidazole and 59 with nimorazole (Table).

Among the patients registered as failures, two, treated with metronidazole, were noted at the first follow-up, and four, treated with nimorazole, at the second follow-up. One patient treated with nimorazole was noted as a failure at the third follow-up.

The results of the tests of cure are presented in the Table. In the group of patients with trichomoniasis but without gonorrhoea who were treated with metronidazole, 48 out of 50 (96 per cent.) were cured, while 48 of 53 (90-5 per cent.) treated with nimorazole were cured. Thus there was no significant difference ($\chi^2 = 0.49; P = 0.5$). In the group of patients with trichomoniasis and gonorrhoea, 37 out of 41 (90.2 per cent) were cured. There was no difference in the results of treatment with nimorazole in patients with or without gonorrhoea.

**Side-effects of antitrichomonal therapy**

Four patients treated with metronidazole developed raised S-GOT and S-GPT. (The rise was slight in two, two-fold in one, who was an alcoholic, and marked in one, who proved to have hepatitis). Two patients treated with metronidazole complained of nausea. One patient treated with nimorazole complained of dizziness, one (treated for gonorrhoea one week before antitrichomonal therapy) of nausea, and one developed a rash. None of the patients in the study had to discontinue treatment because of side-effects.

**Correlation between antitrichomonal therapy and the prevalence of candidiasis**

The prevalence of *C. albicans* was studied at visits before and at the first follow-up examination after antitrichomonal therapy (in patients without gonorrhoea). Out of a total of 103 patients, two who had been previously negative had positive results to *C. albicans* cultures after therapy; both had been treated with metronidazole.

**Correlation between antitrichomonal therapy and the prevalence of other pathogens**

To provide a control group for the study of the effect, if any, of antitrichomonal therapy on *T. vaginalis* and vice versa, every third patient (a total of 22) was excluded from treatment when antitrichomonal therapy was started. However other patients were left untreated during the period of investigation for various reasons, such as lack of co-operation, and the control group eventually contained fifty patients.

**TABLE Results of antitrichomonal treatment**

<table>
<thead>
<tr>
<th>Treatment group</th>
<th>Drug</th>
<th>Patients treated</th>
<th>Patients cured</th>
<th>Percentage of those followed No. of negative examinations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Defaulted No.</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>Patients without gonorrhoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metronidazole</td>
<td>53</td>
<td>3</td>
<td>48</td>
<td>96</td>
</tr>
<tr>
<td>Nimorazole</td>
<td>59</td>
<td>6</td>
<td>48</td>
<td>90.5</td>
</tr>
<tr>
<td>Patients with gonorrhoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nimorazole</td>
<td>46</td>
<td>5</td>
<td>37</td>
<td>90.2</td>
</tr>
</tbody>
</table>
During the follow-up of the gonococcal infection all of these showed persistence of *T. vaginalis*.

The treatment for trichomoniiasis had no demonstrable effect on the results of the antgonococcal therapy, but the number of failures in the treatment of gonorrhoea, with both ampicillin and doxycycline, was very low (Enfors and Eriksson, 1975), so that a very large series would have been required to demonstrate any such effect.

No increase in the frequency of *C. albicans* was observed after the antgonococcal therapy.

In 552 patients without any treatment, 404 had no finding of *C. albicans* at the first and second visit, thirty had negative findings at the first visit and positive at the second, and in 29 patients the opposite results were obtained.

**Discussion**

A trichomoniiasis cure rate of about 90 per cent after one week of treatment with metronidazole has been reported by Rodin, King, Nicol, and Barrow (1960) and Csonka (1963). Similar good therapeutic results have been reported for nimirazole (Cohen, 1971; Moffet, McGill, Schofield, and Masterton, 1971). In a comparative study of randomized treatments, McClean (1972) obtained equivalent results with both preparations (cure rate 82 per cent.) whereas Evans and Catterall (1971) and McCann, Mahony, and Harris (1972) obtained less satisfactory results with nimirazole than with metronidazole.

In our study we found no difference in the results of treatment with metronidazole and nimirazole (cure rates of 96 and 90 per cent. respectively), and both can be regarded as very good. The number of defaulters was comparatively low, but the observation period was fairly short.

**Possible causes of therapeutic failure in the treatment of trichomoniiasis**

The risk of re-infection is high as the patients who attend a venereal clinic are sexually active and the possibility of re-infection will increase during long observation periods.

Patients may not complete the prescribed course of treatment. A demonstration of the significance of these factors was provided by Keighley (1971), who obtained a cure rate of 98 per cent among patients in prison with supervised medication.

Poor absorption of the drug, conversion into inactive metabolites, and inactivation of the vaginal flora have been suggested as causes of therapeutic failure (Kane, McFadzean, and Squires, 1961; Cohen, 1971; Nicol, Evans, McFadzean, and Squires, 1966). McFadzean, Pugh, Squires, and Whelan (1969) found no evidence of primary or acquired resistance after 8 years of treatment with metronidazole. According to de Carneri (1970), experimentally produced metronidazole-resistant strains were still sensitive to nimirazole, whereas Benazet and Guillaume (1972) demonstrated cross-resistance. The good therapeutic results with metronidazole provide evidence that no clinically important resistance develops. In assessing cure, cultures have proved to be superior to microscopy, particularly in cases with occasional trichomonads (Eriksson and Wanger, 1975).

**Correlation between antitrichomonal therapy and the prevalence of C. albicans**

Antitrichomonal therapy has been considered to be one of the contributory factors in the increasing frequency of *C. albicans* (Csonka, 1963; Catterall, 1971; Keighley, 1971; Ross, 1973), but we have not observed any such increase in the prevalence of *C. albicans* after antitrichomonal therapy in our series.

**References**

Benazet, F., and Guillaume, L. (1972) *Lancet*, 1, 597  
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