



Lower Genital Tract Infections in Women

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Introduction

Lower reproductive tract infections (RTIs) in women are a prevalent clinical problem and one of the leading causes of morbidity. Lower genital tract disorders affect the female reproductive system's lower part, which includes the vagina, vulva, and lower cervix. Lower genital tract infections are one of the most common causes for sexually active adult women to seek medical attention. Few women have not had at least one vaginal infection, and a significant proportion of women struggle with severe or often recurring symptoms.

These diseases are caused by microorganisms and are classified into two types: sexually transmitted infections (STIs) and vaginal flora overgrowth. Although the absolute frequency and relative percentage of infectious vaginitis varies by community, there are three primary causes of vaginitis: bacterial vaginosis, formerly known as nonspecific vaginitis (40–50%), candidiasis (20–30%), and trichomoniasis (20–30%). An extra 5% of women have vaginitis that has not been properly diagnosed. The amount of women who complain of vaginal discharge caused by cervicitis has not been thoroughly researched, but cervicitis is chronically underdiagnosed, and including cervicitis in this statistics would underline the relevance of lower genital tract infection even more.

Vaginitis is a common gynecologic issue that affects

women of all ages. Vaginitis generally has vague symptoms, therefore laboratory testing are required to establish the diagnosis. Although vulvovaginitis is usually the consequence of infection, it can also be caused by noninfectious factors such as hypersensitivity, allergic and chemical responses, and contact dermatitis. The typical pH level of the vaginal cavity is around 4.5. A wet-preparation slide mount should show growing yeast and hyphae with the addition of 10% to 20% potassium hydroxide solution, even though this test may fail to show the fungus in 30% to 50% of infected women. In that instance, an evaluation can be performed based on the pH, clinical characteristics, and a negative whiff test. The organisms may also be seen on a typical normal saline wet-mount slide. Topical antifungal medications are often imidazoles (clotrimazole, miconazole, butoconazole, tioconazole, and econazole) or triazoles (terconazole). Cure rates are almost the same whether the regimen is three or seven days long. Fluconazole is effective when taken orally in a single dose of 150 mg.

Recurrent candida infections from the same or other strains may benefit from indefinite continuing daily oral therapy with ketoconazole or fluconazole. Only topical azole treatments should be used for 7 days during pregnancy. Maintenance regimens such as clotrimazole 500 mg vaginal suppositories once weekly or fluconazole 100-150-mg oral dosage once weekly may be administered for 6 months in situations of recurrent vulvovaginal candidiasis. Metronidazole is equally successful as metronidazole in achieving cure rates of 80 to 90 percent.

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