BCCNP
British Columbia College of Nursing Professionals

COLLEGE OF MIDWIVES OF BRITISH COLUMBIA

# BC COLLEGE OF NURSES & MIDWIVES

As of Sept. 1, 2020, the British Columbia College of Nursing Professionals (BCCNP) and the College of Midwives of British Columbia (CMBC) amalgamated to create a new regulatory body: British Columbia College of Nurses & Midwives (BCCNM).

The document you are about to access reflects our most current information about this topic, but you'll notice the content refers to the previous regulatory college that published this document prior to Sept. 1, 2020.

We appreciate your patience while we work towards updating all of our documents to reflect our new name and brand.

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BC CN & M British Columbia College of Nurses & Midwives

# STANDARDS, LIMITS and CONDITIONS for PRESCRIBING, ORDERING and ADMINISTERING DRUGS for SEXUALLY TRANSMITTED INFECTIONS

Under Schedule B of the *Midwives Regulation*, midwives with specialized training, who are certified by the College of Midwives of BC (CMBC), may prescribe, order and administer drugs for the treatment of sexually transmitted infections (STIs). Specialized practice certification in this competency area may be obtained through a course or program established or approved under the authority set out in the *Bylaws for the CMBC*.

The following standards, limits and conditions apply to the drugs that midwives with specialized practice certification in sexually transmitted infections management may prescribe, order and administer in the community, hospital or other sites of midwifery practice. **Midwives without specialized practice certification in this competency area must refer clients for treatment of STIs to an appropriate health care provider.** Midwives may not independently prescribe, order or administer any other drugs for the treatment of STIs unless, on the advice of CMBC's Standards of Practice Committee, these standards are amended consistent with the Schedule A and B of the *Midwives Regulation* or the government amends the Schedules to the *Midwives Regulation*.

The following standards, limits and conditions include general prescribing standards as well as indications, routes of administration and upper dosage limits where appropriate, for the drugs that may be prescribed, ordered or administered by midwives with specialized practice certification in sexually transmitted infections management. Midwives may only prescribe, order or administer drugs for the treatment of sexually transmitted infections according to the standards, limits and conditions set out in this document and to clients under their professional care.

## GENERAL PRESCRIBING STANDARDS

**Midwives:**

1. Prescribe therapeutics within their scope of practice, and in compliance with relevant federal and provincial legislation and organizational policies.

2. Are accountable for their prescribing decisions.

3. Adhere to relevant guidelines when prescribing.

4. Prescribe according to best evidence.

5. Before prescribing, ensure they are competent to:
    a. establish or confirm a diagnosis for the client;
    b. manage the treatment and care of the client; and
    c. monitor and manage the client's response to the therapeutic.

6. When prescribing:
    a. consider the client's health history and other relevant factors (e.g. age, gender, lifestyle, the client's perspective);

b. undertake and document an appropriate clinical evaluation (e.g. physical examination, review of relevant tests, imaging and specialist reports);
c. obtain the best possible medication history for the client using PharmaNet (when access is available) and other sources;
d. review the medication history and act to address any discrepancies;
e. ask about the client's drug allergies and ensure drug allergy information is accurate;
f. appropriately document the therapeutics prescribed and their indication(s) in the client's medical record;
g. establish a plan for reassessment/follow-up; and
h. monitor and document the client's response to the therapeutic prescribed (as appropriate).

7. When prescribing, provide information to clients about:
   a. potential benefits and risks of the therapeutic;
   b. the expected action of the therapeutic;
   c. the duration of therapy;
   d. specific precautions or instructions for the therapeutic;
   e. potential side-effects and adverse effects and action to take if they occur;
   f. potential interactions between the therapeutic and certain foods, other drugs, or substances; and
   g. recommended follow-up.

8. Complete prescriptions accurately and completely, including:
   a. the date the prescription was written;
   b. client name, address (if available), PHN (if available) and date of birth;
   c. client weight (if required);
   d. name, strength and dose of the therapeutic;
   e. the quantity prescribed and quantity to be dispensed;
   f. dosage instructions (i.e. frequency or interval, maximum daily dose, route of administration, duration of therapy);
   g. refill authorization if applicable, including number of refills and interval between refills;
   h. their name, address, telephone number, written (not stamped) signature, and CMBC number;
   i. date of transmission, the name and fax number of the pharmacy intended to receive the transmission, and their fax number if the prescription is being faxed; and
   j. directions to the pharmacist not to renew or alter if a pharmacist-initiated adaption would be clinically inappropriate.

9. Document all verbal orders and telephone prescriptions accurately, contemporaneously and legibly in the client record.

10. Undertake medication reconciliation to ensure accurate and comprehensive medication information is communicated consistently.

11. Report adverse drug reactions to the Canada Vigilance Program[1].

[1] Health Canada's surveillance program that collects and assesses reports of suspected adverse reactions to health products marketed in Canada.

12. Manage, document, report and disclose any medication errors.

13. Do not prescribe therapeutics for themselves or a family member except in an urgent or emergent situation when there is no other prescriber available.

14. Do not provide anyone with a blank, signed prescription.

## Standards, Limits and Conditions for Prescribing, Ordering and Administering Drugs for Sexually Transmitted Infections

Midwives with specialized practice certification in sexually transmitted infections management may prescribe treatment for the following infections: bacterial vaginosis, chlamydia, gonorrhea and trichomoniasis.

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## A) Antibiotics for Bacterial Vaginosis *(updated August 2019)*

Bacterial Vaginosis (BV) is caused by an overgrowth of genital tract bacteria and a deficiency of lactobacilli.

Although BV is not usually categorized as a sexually transmitted infection, it is commonly included as part of the list of sexually transmitted infections. BV during pregnancy is associated with premature rupture of the membranes, chorioamnionitis, preterm labour, preterm birth and post-cesarean delivery endometritis. The Society of Obstetricians and Gynecologists of Canada (2015) recommends reserving treatment of BV in pregnancy for 1) those that are symptomatic and 2) those who are asymptomatic and at high risk for premature labour. The goal in treatment is to eliminate symptoms and to reduce the risk of preterm pre-labour rupture of the membranes and low birth weight.

Metronidazole is the preferred treatment for BV in pregnancy. Clindamycin is considered a suitable alternate treatment when indicated.

### Metronidazole *(updated August 2019)*

Metronidazole is an oral antibiotic classified as an antiprotozoal with bactericidal, amebicidal and trichomonacidal action. It is readily taken up by anaerobic organisms causing disruption of DNA helical structure, inhibition of protein synthesis and cell death.

Indications and Clinical Use:
Metronidazole is the preferred treatment for BV (as well as for the treatment of trichomoniasis - please refer to the entry on trichomoniasis for more information). If symptoms of BV persist after the prescribed course of treatment, a consultation with a physician is required.

Contraindications:
Hypersensitivity to metronidazole or other nitroimidazole derivatives.

Warnings and Precautions:
Use with caution in those with CNS disease: may cause seizures, encephalopathy, peripheral neuropathy (which may be characterized as numbness or paresthesia of an extremity), urticaria, pruritus, flushing, nasal congestion, fever and/or transient joint pain. Metronidazole can also prolong the QTc interval.

To reduce the incidence of drug-resistant bacteria, use only for the treatment of confirmed infections. Candidiasis may present during metronidazole therapy: concurrent treatment with an appropriate antifungal is recommended.

Avoid alcohol for 12 hours before, while on drug therapy and for 24-48 hours after finishing. Drug therapy can cause headache, abdominal cramps, nausea, vomiting, flushing, and/or sweating.

Pregnancy:
Current data does not suggest metronidazole poses an increased risk of anomalies when used in pregnancy or have other harmful effects on the fetus.

Lactation:
Limited Data - Probably Compatible - Although the relative infant dose is > 10% this medication is considered suitable in lactation as numerous reports have found few adverse effects in breastfed infants. This medication is also considered suitable for use in both the neonatal and pediatric population.

Adverse Reactions:
Headache, dizziness, changes in vision, dry mouth, metallic taste, furry tongue, glossitis, nausea, vomiting, diarrhea or constipation, abdominal pain, anorexia, changes in liver function, darkening of the urine and/or rash.

Drug Interactions
Alcohol, lithium, aripiprazole, certain SSRIs, mebendazole, warfarin, phenytoin, or QTc prolonging medications.

Dosage and Administration:
**Bacterial Vaginosis (BV)**
Metronidazole: 500 mg orally twice daily for 7 days;
or
0.75% gel, one applicator (5g) intravaginally OD for 5 days.

With regular tablets or capsules, food decreases the rate of absorption and peak plasma concentrations. With extended release tablets, food increases rate of absorption and peak plasma concentrations. Food does not change the total amount of drug absorbed.

Onset of Action:
Peak plasma concentrations: 1-3 hours following dose.

Metabolism
Approximately 30–60% of an oral metronidazole dose is metabolized in the liver by hydroxylation, side-chain oxidation, and glucuronide conjugation. The major metabolite, 2-hydroxy metronidazole, has some antibacterial and antiprotozoal activity.

Duration of Action:
Half-life elimination: 6-8 hours
Excretion: urine (60-80%), feces (6-15%)

**Clindamycin** *(updated August 2019)*
Clindamycin is a lincosamide, a type of antibiotic that inhibits bacterial protein synthesis.

Indications and Clinical Use:
Clindamycin is used as an alternate treatment to metronidazole for BV. If symptoms persist after the prescribed course of treatment, a consultation with a physician is required.

Contraindications:
Known hypersensitivity or allergy to Clindamycin or Lincomycin.

Warnings and Precautions:
**Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis. With any diarrhea after taking clindamycin, maternal stool should be tested for *C. difficile*. A positive test for**

***C. difficile* is an indication for physician consult.** CDAD has been observed >2 months post-antibiotic treatment.

To reduce the incidence of drug-resistant bacteria, use only for the treatment of confirmed infections. Candidiasis may present during clindamycin therapy; concurrent treatment with an appropriate antifungal is recommended.

Pregnancy:
Compatible: No reports linking use of clindamycin with congenital defects have been located.

Lactation
Limited Data- Probably Compatible- clindamycin is considered suitable in lactation, as numerous reports have found few adverse effects in breastfed infants. The relative infant dose is 0.9-1.8% (less than 10% considered suitable). This medication is also considered suitable for use in both the neonatal and pediatric population.

Clindamycin, like all antibiotics, has the potential to cause adverse effects on the breastfed infant's gastrointestinal flora. If oral or intravenous Clindamycin is required by a nursing mother, it is not a reason to discontinue breastfeeding. Monitor the infant for possible effects on the gastrointestinal flora, such as diarrhea, candidiasis (thrush, diaper rash) or rarely, blood in the stool indicating possible antibiotic-associated colitis.

Adverse Reactions:
Nausea, vomiting, diarrhea, abnormal liver function, serious skin rashes and/or agranulocytosis.

The following side effects should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and/or diarrhea.

Dosage and Administration:
**Bacterial Vaginosis**

| | |
|---|---|
| Clindamycin: | 300 mg orally twice daily for 7 days;<br>or<br>2% cream, one applicator (5g) intravaginally once a day for 7 days. |

Onset of Action:
Absorption is rapid; widely distributed into most body tissues and fluids, including gallbladder, liver, kidneys, bone, sputum, bile, and pleural and synovial fluids.

Onset of Action:
Peak plasma concentrations: 1 hour following dose.

Duration of Action:
Half-life elimination: 3 hours.

Half-life:
Excretion: urine (10%), feces (4%) as active drug and metabolites.

## B) Antibiotics for Chlamydia *(updated August 2019)*

Chlamydia is the most common sexually transmitted bacterial infection in Canada and is caused by the bacterium *Chlamydia trachomatis.* It is reportable to the BC Centre for Disease Control. Chlamydia is commonly undiagnosed unless screened for as the majority of infected individuals are asymptomatic. Screening during pregnancy should occur at the first prenatal visit and if positive, a test of cure is required at 3-4 weeks post antibiotic completion of treatment for pregnant and/or breastfeeding clients. Timely treatment reduces the risk of symptomatic infection with its associated risks. Repeat screening is recommended at six months if client is at high risk of re-infection. Partners also need to be informed, and advised to see their health care provider for assessment, screening and treatment. Untreated chlamydia can be associated with intestinal symptoms, mucopurulent cervicitis, increased vaginal discharge with or without odour, conjunctivitis in neonates and pneumonia in infants less than 6 months of age. Major sequelae may cause pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain and Reiter Syndrome.

Amoxicillin or erythromycin are the preferred options for treatment of chlamydia during pregnancy and lactation. Azithromycin may be considered if poor compliance with treatment is expected. Doxycycline, azithromycin or erythromycin are the preferred treatment options for chlamydia in non-pregnant and non-lactating clients.

### Amoxicillin *(updated August 2019)*

Amoxicillin acts as a broad spectrum bactericidal against many gram-positive and gram-negative microorganisms. This is achieved through the inhibition of biosynthesis of cell wall mucopeptides.

Indications and Clinical Use:
Amoxicillin is considered a first-line treatment for asymptomatic or symptomatic infections caused by *Chlamydia trachomatis* in pregnancy and the postpartum.

Contraindications:
Documented hypersensitivity or allergy to amoxicillin or any other penicillin antibiotic or component of the formulation.

Warnings and Precautions:
Reduces efficacy of oral contraceptives; adjust dose in renal impairment; may enhance chance of candidiasis. Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment. Use with caution in asthmatic patients.

Breastfed infants may develop slightly looser stools than normal. Modification of bowel flora and allergic sensitization of the infant may occur.

Pregnancy:
Human data suggests risk in the 1st and 3rd trimesters. There is some evidence that exposure during organogenesis is associated with oral clefts and necrotizing enterocolitis when used in preterm labour however, the absolute risk is very low and requires confirmation.

Lactation:
Limited Data – compatible.

Less than 0.95% of the maternal dose is secreted into milk which is less than 0.5% of a typical infant dose of amoxicillin. There have been no harmful effects reported.

Adverse Reactions:
Upset stomach, diarrhea, vomiting, vaginal infection and/or mild skin rash. The following should be reported to a medical practitioner immediately: severe skin rash, itching, hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and/or diarrhea.

Dosage and Administration:
**Chlamydia:**
Amoxicillin: 500 mg PO every 8 hours (tid) for 7 days. May be taken with food.

Onset of Action:
Oral: Rapid; food does not interfere with absorption.

Duration of Action:
Peak serum concentrations usually attained within 1–2 hours.

Half-life:
1-1.4 hours.

**Azithromycin** *(updated August 2019)*

Azithromycin is a macrolide anti-infective antibiotic derived from erythromycin. It inhibits RNA dependent protein synthesis and binds to the 50S ribosomal subunit blocking transpeptidation.

Indications and Clinical Use:
For treatment of asymptomatic or symptomatic infections caused by *Chlamydia trachomatis* pregnancy and the postpartum if poor compliance with treatment is expected. It is also used to treat gonococcal infections in pregnancy and the postpartum - for more information, refer to the entry on gonorrhea.

Contraindications:
Documented hypersensitivity or allergy to azithromycin or any component of the formulation and if there is a history of cholestatic jaundice/hepatic dysfunction.

Warnings and Precautions:
Use with caution in those with liver disease. Use should be discontinued with nausea, vomiting and/or fever. Macrolides have been associated with rare QTc prolongation and ventricular arrhythmias. Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment.

Breastfed infants may develop vomiting, diarrhea, and/or rash. Modification of bowel flora in the infant may occur.

Pregnancy:
Compatible
Human data does not suggest risk of toxicity during embryo-fetal development.

Lactation:
Limited Data – probably compatible.
No reported pediatric concerns for neonates exposed to breastmilk.

Adverse Reactions:
Diarrhea, loose stools, abdominal pain, nausea, vomiting.

Dosage and Administration:
**Chlamydia**
Azithromycin: 1g PO in single dose

Onset of Action:
Oral: Rapid; aluminum and magnesium containing antacids may slow absorption of azithromycin.

Duration of Action:
Peak serum concentrations usually attained within 3–4 hours.

Half-life:
48-68 hours.

**Erythromycin** *(updated August 2019)*

Erythromycin is a macrolide anti-infective antibiotic used in the treatment of gram-positive, gram-negative and other microorganisms. Erythromycin acts by inhibition of protein synthesis and binding susceptible organisms.

Indications and Clinical Use:
Erythromycin is considered a first-line treatment for asymptomatic or symptomatic chlamydia in pregnancy and the postpartum.

Contraindications:
Documented hypersensitivity or allergy to erythromycin or any component of the formulation.

Warnings and Precautions:
Use with caution in those with liver disease. Use should be discontinued with nausea, vomiting or fever. Macrolides have been associated with rare QTc prolongation and ventricular arrhythmias. Prolonged use may result in fungal or bacterial superinfection, including *C. difficile*-associated diarrhea (CDAD) and pseudomembranous colitis; CDAD has been observed >2 months post-antibiotic treatment.

Breastfed infants may develop vomiting, diarrhea and/or rash. Modification of bowel flora and allergic sensitization of the infant may occur.

Pregnancy:
Compatible (Excludes estolate salt). No evidence of developmental toxicity with erythromycin has been reported.

Lactation:
Limited Data – probably compatible.

This medication is considered suitable in lactation; the relative infant dose is less than 2%.

Adverse Reactions:
Upset stomach, nausea, vomiting, hepatitis, ototoxicity.

Dosage and Administration:
**Chlamydia:**
Erythromycin: 500 mg PO every 6 hours (qid) for 7 days or if not tolerated;
Erythromycin: 250 mg PO every 6 hours (qid) for 14 days.

Onset of Action:
Oral: Immediate release; may be taken with food to decrease gastrointestinal upset.

Duration of Action:
Peak serum concentrations usually attained within 2–4 hours.
Half-life:
1.5-2 hours.

**Doxycycline** *(updated August 2019)*

Doxycycline is a broad spectrum semisynthetic tetracycline antibiotic. It inhibits protein synthesis by binding with the 30S and possibly 50S ribosomal subunits of susceptible bacteria.

Indications and Clinical Use:
For treatment of asymptomatic or symptomatic infections caused by *Chlamydia trachomatis* in non-pregnant and non-lactating clients.

Contraindications:
Documented hypersensitivity or allergy to doxycycline, tetracycline or any other component of the formulation; severe renal or hepatic dysfunction; myasthenia gravis. **Contraindicated in pregnancy and should be avoided during lactation.**

Warnings and Precautions:
Reduces efficacy of oral contraceptives; may enhance chance of candidiasis; to be used with caution in individuals with asthma, allergies, hay fever and/or urticaria.

Pregnancy:
Tetracyclines cross the placenta and accumulate in developing teeth and bones; can cause maternal liver toxicity and congenital defects.

Lactation:
Limited Data – Probably Compatible
Doxycycline is the least of the tetracyclines to be bound to calcium when secreted into milk and may be better absorbed in a breastfeeding infant. Short term use (3-4 wks) is not contraindicated although its use should be limited to cases where other antibiotic options are unavailable. No harmful effects have been reported.

Adverse Reactions:
Upset stomach, diarrhea, vomiting, vaginal monilial overgrowth and/or skin rash. The following should be reported to a medical practitioner immediately: severe skin rash, itching,

hives, difficulty breathing or swallowing, wheezing, unusual bleeding or bruising, sore throat, painful mouth or throat sores, jaundice and/or diarrhea.

Dosage and Administration:
**Chlamydia:**
Doxycycline: 100 mg PO every 12 hours (bid) for 7 days

If the client misses two consecutive doses of doxycycline within the first 5 days of treatment, or has not completed a full five consecutive days of treatment, retreatment is indicated.

Antacids may slow absorption of doxycycline. Should be taken with a full glass of water.

Onset of Action:
Oral: Administration on an empty stomach is not recommended.

Duration of Action:
Peak serum concentrations usually attained within 1.5-4 hours.

Half-life:
12-22 hours.

## C) Antibiotics for Gonorrhea *(updated August 2019)*

Gonorrhea is the second most common sexually transmitted bacterial infection in Canada and is caused by the bacterium *Neisseria gonorrhoeae*. It is reportable to the BC Centre for Disease Control. Gonoccocal infections may occur in the cervix, fallopian tubes, rectum, throat and urethra. Many individuals are asymptomatic and are unaware of infection. Early symptoms may be mild and may be mistaken for a bladder or mild vaginal infection. Screening during pregnancy should occur at the first prenatal visit and if positive, a test of cure should be repeated at 3-7 days post antibiotic completion of treatment for pregnant and/or breastfeeding clients. Timely treatment reduces the risk of symptomatic infection with its associated risks. Repeat screening is recommended at 6 months if client is at high risk of re-infection. Partners also need to be informed, and advised to see their health care provider for assessment, screening and treatment.

Untreated gonorrhea can lead to complications in the reproductive organs including difficulty getting pregnant, ectopic pregnancy or pelvic inflammatory disease. The infection if untreated can be passed to newborns during birth and may lead to blindness if untreated.

Ceftriaxone IM PLUS azithromycin PO OR cefixime PO PLUS azithromycin PO are the preferred treatment options for gonorrhea during pregnancy or lactation. Azithromycin PO may be considered as an alternate if cephalosporins are contraindicated.

### Cefixime *(updated August 2019)*

Cefixime is an oral antibiotic of the cephalosporin class, related to penicillin.

Indications and Clinical Use:
Cefixime is used in combination with azithromycin for the treatment of asymptomatic or symptomatic gonococcal infections in pregnancy and the postpartum as a first line treatment. It is the only oral cephalosporin that can be used for the treatment of gonorrhea.

Contraindications:
Allergy to cephalosporin group of antibiotics.

Warnings and Precautions:
Chance of cross-reactivity is low (around 3%) if the patient is penicillin sensitive, however do not use it for highly allergic (eg. anaphylactic) patients. Use with caution in patients with colitis.

Alteration of GI flora may occur.

Pregnancy:
Compatible – Limited human pregnancy data do not suggest embryo or fetal risk.

Lactation:
No Data – probably compatible.

Adverse Reactions:
Diarrhea, gas, loose stools, nausea, and stomach upset.

Dosage and Administration:
**Gonorrhea:**
Cefixime: 800mg orally in single dose PLUS azithromycin PO 1g in a single dose

Administer with food

Onset of Action:
Time to peak, serum: 2-6 hours; delayed with food.

Duration of Action:
Half-life elimination: 3-4 hours.

**Ceftriaxone** *(updated August 2019)*

Ceftriaxone is a third-generation broad spectrum semisynthetic cephalosporin antibiotic that causes inhibition of cell wall synthesis, followed by cell lysis.

Indications and Clinical Use:
Ceftriaxone is used in combination with azithromycin for the treatment of asymptomatic or symptomatic gonorrhea in pregnancy and the postpartum.

Contraindications:
Allergy to cephalosporin group of antibiotics.

Warnings and Precautions:
Chance of cross-reactivity is low (around 3%) if the patient is penicillin sensitive, however do not use it for highly allergic (e.g., anaphylactic) patients. Use with caution in clients with colitis.

Alteration of GI flora may occur.

Pregnancy:
Compatible – Use during 1st trimester may be associated with cardiovascular defects.

Lactation:
Limited Data – compatible.

Adverse Reactions:
Adult - Diarrhea, allergic rash, thrush and/or colitis.
Breastfed infant – monitor for vomiting, diarrhea, rash and changes in gastrointestinal flora.

Dosage and Administration:
**Gonorrhea:**
Ceftriaxone: 250 mg IM as a single dose PLUS azithromycin PO 1g in a single dose

Onset of Action:
Time to peak, serum: 1 hour.

Duration of Action:
Half-life elimination: 7.3 hours.

**Azithromycin** *(updated August 2019)*
*For medication details, please refer to entry for azithromycin in the entry on Chlamydia.*

Dosage and Administration:
**Gonorrhea:**
Azithromycin: 1g PO in a single dose PLUS

Ceftriaxone: 250 mg IM as a single dose OR
Cefixime: 800mg PO in single dose

Azithromycin 2 g PO in a single dose is considered as an alternate treatment option if there is a history of severe allergy to cephalosporins.

## D) Antibiotics for Trichomoniasis *(updated August 2019)*

Trichomoniasis is a sexually transmitted infection caused by a protozoa called *Trichomonas vaginalis*. Trichomoniasis may be associated with premature rupture of membranes, preterm birth and/or low birth weight. In pregnancy, treatment of trichomoniasis is warranted. Partners also need to be informed, and advised to see their health care provider for treatment.

Metronidazole is the treatment of choice during pregnancy and lactation.

**Metronidazole** *(updated August 2019)*
*For medication details, please refer to the entry for metronidazole in the section on bacterial vaginosis.*

Dosage and Administration:
**Trichomoniasis:**
Metronidazole: 2g PO in a single dose or 500 mg PO every 12 hours (bid) for 7 days.

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