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CLINICAL PRACTICE UPDATE

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Concurrent Sexual Partner Therapy to Prevent Bacterial Vaginosis Recurrence

This Clinical Practice Update was developed by the American College of Obstetricians & Gynecologists in collaboration with Anna Powell, MD, MSCR; and Jenell Coleman, MD, MPH.

This Clinical Practice Update provides new guidance on the use of sexual partner therapy in the management of bacterial vaginosis based on new research findings and a growing body of evidence implicating sexual activity as an important method of infection transmission. This document is a focused update of related content in Practice Bulletin No. 215, *Vaginitis in Nonpregnant Patients* (Obstet Gynecol 2020;135:e1–17).

BACKGROUND

Recurrent bacterial vaginosis is extremely common after initial therapy, with up to 66% of women experiencing a recurrence within 12 months of treatment (1). (Please see the "Use of Language" section later in this document.) Although the etiology of bacterial vaginosis remains incompletely understood, the available evidence suggests that it is a multifactorial condition influenced by endogenous factors and exogenous exposures, including sexual activity (2, 3). Concurrent male sexual partner therapy has been investigated as a potential strategy to reduce the risk of bacterial vaginosis recurrence, but past studies have not demonstrated a clear benefit (4, 5). Potential reasons for this include the use of oral monotherapy and poor treatment adherence by male partners. For example, in one study, although male partner treatment did not show a significant overall benefit, multivariable modeling found that women had fewer treatment failures when their male partners were more adherent to therapy (adjusted relative risk 0.78, 95% CI, 0.67–0.91) (5). To overcome limitations of prior studies, a recent randomized controlled trial treated male partners of women diagnosed with bacterial vaginosis with a combination of oral and topical antimicrobial agents (instead of oral treatment alone, as in prior studies) and is the first partner therapy study to report a significant reduction in bacterial vaginosis recurrence (6). These new findings, combined with increasing biologic and epidemiologic evidence that sexual activity plays an important role in the transmission of bacterial vaginosis, support the use of concurrent sexual partner therapy in the management of bacterial vaginosis.

UPDATED CLINICAL RECOMMENDATIONS

Concurrent sexual partner therapy with a combination of oral and topical antimicrobial agents should be considered for male sexual partners of adult patients with recurrent, symptomatic bacterial vaginosis.

Shared decision making regarding concurrent sexual partner therapy is recommended for adult patients with recurrent, symptomatic bacterial vaginosis who have same-sex partners and for patients with a first occurrence of symptomatic bacterial vaginosis.

RATIONALE

New Evidence to Support Concurrent Male Partner Therapy

In a 2025 multicenter, open-label, randomized controlled trial that included 137 women diagnosed with bacterial vaginosis and their male sexual partners, female participants in the treatment and control groups received usual therapy with multidose oral metronidazole (twice daily for 7 days) or with intravaginal antibiotic treatment (2% clindamycin cream for 7 nights or 0.75% metronidazole gel for 5 nights) if oral antibiotic treatment was contraindicated (6). Male partners in the treatment group were treated concurrently with multidose oral metronidazole and topical 2% clindamycin cream (2-cm diameter of cream applied twice daily for 7 days to the glans penis, or under the foreskin if uncircumcised, and the upper shaft) (6). All study

participants were asked to abstain from sexual intercourse during the 7-day treatment. Trial recruitment was stopped early when investigators observed that standard therapy was clearly inferior to partner therapy at 12 weeks: relapse infection occurred in 35% of participants in the treatment group (recurrence rate 1.6/person-year, 95% CI, 1.1–2.4) compared with 63% in the control group (recurrence rate, 4.2/person-year, 95% CI, 3.2–5.7), which corresponded to an absolute risk difference of −2.6 recurrences per person-year (95% CI, −4.0 to −1.2) (6). All women reported taking at least 70% of their prescribed medication, and bacterial vaginosis recurrence risk was lowest (1.3/person-year, 95% CI, 0.7–2.6) among those whose male partner reported 100% treatment adherence. The most commonly reported systemic adverse effects were those already known to be associated with oral metronidazole treatment, including nausea, headache, and a metallic taste in the mouth. Up to 7% of male partners reported mild penile irritation or redness. No serious adverse events were reported (6).

Although these results are significant, the study did have several limitations. Only monogamous heterosexual couples were enrolled, and most female participants had at least one risk factor for recurrent infection (eg, history of bacterial vaginosis, intrauterine device use, uncircumcised male partner) (6), which may limit the generalizability of the results. Longer-term studies are needed to determine, for example, whether male partner maintenance therapy is needed and whether sexual partner treatment is effective in broader populations, including women who have sex with women, individuals in nonmonogamous relationships, and patients with incident or asymptomatic bacterial vaginosis.

Sexual Transmission of Bacterial Vaginosis

The use of sexual partner therapy to prevent bacterial vaginosis recurrence is further supported by an increasing and robust body of evidence that demonstrates the sexual transmission of bacterial vaginosis. Incident bacterial vaginosis has a similar incubation period to bacterial sexually transmitted infections (7). Bacterial vaginosis occurs predominantly in sexually active populations and is rare among individuals with no history of sexual activity (8). Observational studies have repeatedly demonstrated an association between bacterial vaginosis incidence and exposure to new or multiple sexual partners (9–11), and bacterial vaginosis recurrence risk is highest among women with a regular sexual partner (12–14). Microbiologic evidence supports the exchange of bacterial vaginosis–associated bacteria between female and male sexual partners (15–20). Interventions such as consistent condom use, which reduces the exchange of genital secretions, are associated with lower incidence and recurrence rates of bacterial vaginosis (12).

Concurrent Female Partner Therapy

Although the use of concurrent partner therapy for the prevention of bacterial vaginosis recurrence among female couples is an emerging area of investigation (21), its use is supported by epidemiologic and microbiologic evidence that suggests the sexual exchange of bacterial vaginosis between female sexual partners is an important mechanism of transmission. For example, the risk of incident and recurrent bacterial vaginosis is increased in women who report having new or multiple female sexual partners, particularly those who report symptoms or a history of bacterial vaginosis (10–12, 22). In addition, studies of the vaginal microbiota of monogamous female couples demonstrate high concordance for both normal flora and bacterial vaginosis–associated species (11, 22, 23).

IMPLEMENTATION CONSIDERATIONS

Based on the eligibility requirements of the male partner therapy trial (6), ideal candidates for concurrent partner therapy for bacterial vaginosis are patients with symptomatic, recurrent infection who are in a monogamous relationship and have a regular male sexual partner. Shared decision making is recommended for patients who do not meet these criteria. For these patients, the unclear therapeutic benefit needs to be weighed against considerations such as adverse treatment effects and possible out-of-pocket costs for partner therapy.

Male partners and same-sex partners of patients with recurrent, symptomatic bacterial vaginosis should be encouraged to seek evaluation and treatment from their own health care practitioners. When a partner lacks access to care, the patient's clinician may consider providing a prescription to a same-sex partner after a patient–physician relationship has been established. Clinicians should adhere to local regulations and institutional policies when determining whether and how to establish a patient–physician relationship with a male partner. Although the American College of Obstetricians & Gynecologists (ACOG) supports the practice of expedited partner therapy (24), this is not a recommended strategy for the management of bacterial vaginosis, because the provision of expedited partner therapy is regulated by state and local laws that generally permit its implementation only in cases of chlamydial infection, gonococcal infection, and, sometimes, trichomoniasis (25). Clinicians should refer to their state and local health departments for the most current guidelines on the provision of expedited partner therapy.

Patient counseling should address expected adverse effects for female and male patients (eg, nausea and metallic taste with oral metronidazole [500 mg twice daily for 7 days], potential mild penile irritation with 2% clindamycin cream [applied twice daily for 7 days]). Clinicians

should emphasize the importance of abstinence during treatment and strict adherence to the treatment regimen for both partners (6). As an alternative to abstinence, male partners should use a condom during sexual activity to reduce the risk of reinfection. Patients and their partners also should be made aware of the potential for out-of-pocket treatment costs, because sexual partner therapy for bacterial vaginosis may not be covered by insurance.

For additional information about the prevention and treatment of bacterial vaginosis, please see related guidance from ACOG (26) and from the Centers for Disease Control and Prevention (8).

USE OF LANGUAGE

ACOG recognizes and supports the gender diversity of all patients who seek obstetric and gynecologic care. In original portions of this document, the authors seek to use gender-inclusive language or gender-neutral language. When describing research findings, this document uses gender terminology reported by the investigators. ACOG's policy on inclusive language can be reviewed at https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language.

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CONFLICT OF INTEREST STATEMENT

All ACOG committee members and authors have submitted a conflict of interest disclosure statement related to this published product. Any potential conflicts have been considered and managed in accordance with ACOG's Conflict of Interest Disclosure Policy. The ACOG policies can be found on acog.org. For products jointly developed with other organizations, conflict of interest disclosures by representatives of the other organizations are addressed by those organizations. The American College of Obstetricians & Gynecologists has neither solicited nor accepted any commercial involvement in the development of the content of this published product.

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