Gynecology case study 6

A 25 year old nulligravid came to the OPD because of vaginal discharge, which started 7 days prior to consult. No associated vaginal pruritus, fever, pelvic pain, urinary or bowel symptoms noted.

She is an office clerk, and is currently in a monogamous relationship with her male partner for 3 years. Past medical and family histories are unremarkable. She has regular menses, coming in every 30 days, lasting 3-4 days, and using up 3 pads per day. She is a nonsmoker, and a non-alcoholic beverage drinker

On PE, she has stable vital signs, and afebrile. Examination of the heart and lungs were normal. Her abdomen is flat, soft and nontender.

On speculum exam, there was copious thin, whitish-gray homogenous, foul-smelling discharge noted in the vagina.

On IE, she has normal external genitalia, smooth nulliparous vagina, cervix was firm, uterus small, with no adnexal masses or tenderness.

Rectovaginal exam: smooth and pliable rectovaginal septum and parametria; no rectal masses noted

Questions:

1. What is your initial diagnosis?
2. Give your differential diagnosis, and how will you rule out each?
3. Give the criteria for diagnosis of this condition:
4. What laboratory exams will you request
5. How will you manage this patient?