Prevalence and Correlates of *Gardnerella vaginalis* and *Trichomonas vaginalis* among Female Students in Bingham University

L. Y. Adogo¹*, E. A. Oyewole¹, N. C. J. Anyanwu¹ and P. E. Omebije²

¹Department of Biological Sciences, Faculty of Science and Technology, Bingham University, Karu, Nigeria.
²Department of Microbiology, Faculty of Natural Sciences, Kogi State University, Ayingba, Nigeria.

Authors’ contributions

This work was carried out in collaboration between all authors. Author EAO did the study design and wrote the protocol. Authors LYA and NCJA did the statistical analysis and literature searches while analyses of the study was done by authors LYA and PEO. All authors read and approved the final manuscript.

Article Information

DOI: 10.9734/IJTDH/2016/29115

Editor(s):
(1) Triveni Krishnan, Division of Virology, National Institute of Cholera and Enteric Diseases, Kolkata, India.
(2) Shankar Srinivasan, Department of Health Informatics, University of Medicine & Dentistry of New Jersey, USA.

Reviewers:
(1) Maria Demetriou, Democritus University of Thrace, Greece.
(2) Angel Ramos-Ligorio, University of Veracruz, Mexico.
(3) Anonymous, Dedan Kimathi University of Technology, Kenya.

Complete Peer review History: [http://www.sciencedomain.org/review-history/17145](http://www.sciencedomain.org/review-history/17145)

Received 23rd August 2016
Accepted 17th November 2016
Published 6th December 2016

ABSTRACT

**Aim:** To determine the prevalence of *Gardnerella vaginalis* and *Trichomonas vaginalis* among female students in Bingham University.

**Place and Duration of Study:** The study was carried out in the Department of Biological Sciences, Bingham University, Karu between the months of March to June 2016.

**Study Design:** A cross-sectional study design was utilized.

**Methodology:** Low vaginal swabs were collected from 200 female students. *G. vaginalis* was identified using wet mount, whiff test and culture in chocolate media. *Trichomonas vaginalis* was identified by making wet mounts of vagina swabs and viewing for viable organism under x10 and x40 objectives of the light microscope.

*Corresponding author: Email: adogolillian@gmail.com*
Keywords: Bacterial vaginosis; Gardnerella vaginalis; Trichomonas vaginalis; prevalence.

1. INTRODUCTION

Bacterial vaginosis (BV) is a vaginal infection that occurs when the equilibrium of the natural flora in the vagina is altered. It is the most common cause of abnormal vaginal discharge [1,2] affecting millions of women of reproductive age annually.

The vaginal flora are the microorganisms that colonize the vagina. The amount and type of bacteria present have significant implications for a woman’s overall health. The primary colonizing bacteria of a healthy individual are of the genus Lactobacillus e.g. Lactobacillus crispatus [3]. It is generally accepted that the production of lactic acid by these bacteria protect females against infection by pathogenic species [4,5,6].

Approximately, 95% of vaginitis is caused by one of the three organisms; Candida albicans, Trichomonas vaginalis and Gardnerella vaginalis [7] and these organisms are among the leading infectious agents causing vaginitis among young women in urban communities in Nigeria [8].

The key player in the pathogenesis of Bacterial vaginosis and the development of a biofilm is Gardnerella vaginalis. It was shown in a study of microbiota on the epithelial surfaces of vaginal biopsy specimens from women with bacterial vaginosis, that a biofilm adhered to parts of the epithelium and Gardnerella vaginalis comprised 90% of bacteria in that biofilm [9]. Gardnerella vaginalis is a gram-variable facultative anaerobe characterized by fastidious, beta-hemolytic growth. It is non-motile and un-encapsulated in nature. The bacilli produces a pore forming toxin, vaginolysin which affects only human cells and has been demonstrated by many studies to have a relationship with other bacteria such as Lactobacillus species, Prevotella, and anaerobes like Mobiluncus and Bacteroides [10].

Common symptoms associated with vaginosis in women, caused by G. vaginalis include increased foul smelling (usually smells like fish) vaginal discharge. The discharge is often white or grey in colour. The smell is particularly noticeable after intercourse. Semen is alkaline and it reacts with the bacteria thereby causing the release of chemicals, hence the fishy smell. There may be burning sensation with urination [11].

Trichomonas vaginalis is an anaerobic, parasitic, flagellate protozoan. It is also a member of the Parabasalia, and is the causative agent of trichomoniasis [12]. T. vaginalis, principally infects the squamous epithelium in the urogenital tract: vagina, urethra, and paraurethral glands [13]. Other less common sites include the cervix, bladder, Bartholin glands, and prostate. Humans are the only known host with the trophozoite transmitted principally via vaginal sexual intercourse, and rarely via fomites [14].

T. vaginalis which is the causative agent of trichomoniasis, can cause vaginitis, cervicitis, urethritis and is the most prevalent non-viral sexually transmitted infection worldwide [12], with an estimated 180 million infection acquired annually worldwide [15]. Coexistence of T. vaginalis and bacterial vaginosis pathogens is common, with coinfection rates of 60 to 80 percent [16].
Bacterial vaginosis and trichomoniasis are responsible for different infections and have been linked to premature labour, preterm delivery, low birth weight, increase prenatal mortality in pregnant women. They also predispose their patients to HIV/AIDS [17]. Some recent studies also provide evidence that trichomoniasis predispose many to certain malignant disease such as prostate and cervical cancer [18].

Nearly half of all women with *G. vaginalis* and *T. vaginalis* are asymptomatic [19,20] and they may not be aware that they have the infection. It is important that more effective and safe diagnosis and therapeutics be made to ensure that *G. vaginalis* which could be present as a normal microflora in some women, does not exceed its number or be found in other sites as it is not just confined to the lower genital tract in bacterial vaginosis [21].

2. METHODOLOGY

2.1 Study Area

The study was carried out in Bingham University, Karu, Nasarawa state. The school is located in Auta Balefi; a community situated in the middle belt of Nigeria at Longitude 8°32’ N 8°18’ E and Latitude 8.533° N 8.300° E. It is characterized by a tropical sub-humid climate with two distinct seasons; wet and dry seasons. Monthly temperature ranges from 20ºC to 34ºC and annual rainfall ranging from 1100 mm to about 2000 m [22]. It occupies a land mass of over 200 square meters, and it is 23 kilometers away from Abuja [23].

2.2 Study Population

Two hundred female students of Bingham University between the age group of 15-35 years were randomly recruited for the study.

2.3 Exclusion Criteria

Students who were currently on their period at the time of the study were excluded from the study.

2.4 Ethical Approval

Ethical approval was obtained from the ethical committee of Bingham University.

2.5 Sample Collection

Vaginal swabs were collected from 200 female students. They students were enlightened on the causative agents of the diseases, and the appropriated method of collecting the required sample was demonstrated by the nurses. Sterile cotton tipped swab was inserted into the exterior vaginal fornix and low vaginal swabs (LVS) was taken.

2.6 Laboratory Identification of Microorganisms

Whiff-amine test was used to test for the production of a fishy smell as described by Amsel et al. [24]. Microscopic examination was carried out to determine the presence of clue cells using X40 objective. A swab containing vaginal discharge was inoculated on Chocolate agar and incubated at 33°C in a 5-10% CO₂ incubator. The plates were examined macroscopically for *Gardnerella vaginalis*. Biochemical tests (Catalase and Indole tests) were carried out. Antibiotic sensitivity test was carried out using 5 mg metronidazole as control.

*Trichomonas vaginalis* was identified by making wet mounts of vagina swabs and viewing for viable organism under x10 and x40 objectives of the light microscope. *Trichomonas vaginalis* was identified by its characteristic pear shape [25].

2.7 Statistical Analysis

The data obtained was subjected to bivariate analysis using correlation coefficient. A confidence interval of 75% was also used and Chi square test was used to determine if there is a significant relationship between the infections and the factors considered.

3. RESULTS

Two hundred female students were screened for *Gardnerella vaginalis* and *Trichomonas vaginalis* infection. There were 69 positive samples for *G. vaginalis* and 9 positive samples for *T. vaginalis*, thus, constituting a prevalence rate of 34.5% and 4.5% respectively as shown on Table 1. The prevalence in this study is 39.0% at 75% confidence index.

Table 2 shows the age distribution of *G. vaginalis* and *T. vaginalis*. A high prevalence rate was recorded within the age group of 15-20 yrs (24.50%), (4.0%) for *G. vaginalis* and *T. vaginalis* respectively. Similarly, a low prevalence rate was recorded at 26-30 yrs for *G. vaginalis* (1.0%) and 21-25 yrs for *T. vaginalis* (0.5%). Statistical
analysis shows that prevalence of *G. vaginalis* and *T. vaginalis* infection is associated with the age of the participants (p<0.05).

Table 3 shows the prevalence rate of *G. vaginalis* and *T. vaginalis* with respect to presence of symptoms. 73 of the participants in this study were symptomatic, 127 were asymptomatic. The peak of the infection in symptomatic individuals with *G. vaginalis* was recorded with those who had discharge alone; 12(16.43%) and those who had itching alone had the least prevalence of 5.47%. With respect to *T. vaginalis*, the prevalence was similar (1.36%) for those who had itching alone, discharge alone and discharge with itching.

Table 4 shows the prevalence rate of *G. vaginalis* and *T. vaginalis* with respect to predisposing factors that may enhance the infection transmission. Those that douched had a higher prevalence (20.8%) of *G. vaginalis* followed by those that were sexually active (4.69%). For *T. vaginalis*, prevalence (0.67%) was similar for all the risk factors.

Table 5 shows the coinfection rate of *G. vaginalis* with *T. vaginalis* on the basis of age. A coinfection rate of 4.5% was recorded. Coinfection was greater among the age group 15-20 yrs; 4.0%.

Table 6 shows the results of bivariate analysis using correlation coefficient. Tables 7 and 8 represents the Chi square values for *Gardnerella vaginalis* and *Trichomonas vaginalis* with respect to age, symptoms and risk factors.

### 4. DISCUSSION

The prevalence of *G. vaginalis* in the vaginal swab samples collected and examined in this study is 34.5%. The high prevalence in this study may be related to the physiology and abnormal changes that occur in women of reproductive age at some point in their lifetime. It could also be, probably due to improper hygienic conditions that range from the use of medicated and highly caustic soap to wash the vagina and use of sanitary pads for long period of time during menstruation which could increase the risk of acquiring the infection. The prevalence of *G. vaginalis* in this study is higher than the findings of Isiaka-Lawal et al. [26], Okonko et al. [27] and Usanga et al. [28] who recorded...
Table 4. Prevalence of *G. vaginalis* and *T. vaginalis* on the basis of predisposing factors that may enhance the infections

<table>
<thead>
<tr>
<th>Risk factors</th>
<th>No. indicated</th>
<th><em>Gardnerella vaginalis</em></th>
<th><em>Trichomonas vaginalis</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No. of positive</td>
<td>Prevalence (%)</td>
</tr>
<tr>
<td>Douching</td>
<td>109</td>
<td>31</td>
<td>20.80</td>
</tr>
<tr>
<td>Smoking</td>
<td>4</td>
<td>2</td>
<td>01.34</td>
</tr>
<tr>
<td>STI acquisition</td>
<td>8</td>
<td>2</td>
<td>01.34</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>28</td>
<td>7</td>
<td>04.69</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>42</td>
<td>28.17</td>
</tr>
</tbody>
</table>

Table 5. Coinfection rate of *G. vaginalis* and *T. vaginalis* with respect to age

<table>
<thead>
<tr>
<th>Age (yrs)</th>
<th>No. screened</th>
<th>Coinfection of <em>G. vaginalis</em> and <em>T. vaginalis</em></th>
<th>Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>124</td>
<td>8</td>
<td>4.00</td>
</tr>
<tr>
<td>21-25</td>
<td>70</td>
<td>1</td>
<td>0.50</td>
</tr>
<tr>
<td>26-30</td>
<td>6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>31-35</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>9</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Table 6. Bivariate analysis showing correlation coefficient results

<table>
<thead>
<tr>
<th>Factors considered</th>
<th>Calculated correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.2065</td>
</tr>
<tr>
<td>Symptoms</td>
<td>0.5863</td>
</tr>
<tr>
<td>Risk factors</td>
<td>0.4086</td>
</tr>
</tbody>
</table>

Table 7. Chi square values for *Gardnerella vaginalis* with respect to age, symptoms and risk factors

<table>
<thead>
<tr>
<th>Factors considered</th>
<th>Chi square value ($\chi^2$)</th>
<th>P values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>89.193</td>
<td>0.00001</td>
</tr>
<tr>
<td>Symptoms</td>
<td>4.002</td>
<td>0.28569</td>
</tr>
<tr>
<td>Risk factors</td>
<td>54.949</td>
<td>0.00001</td>
</tr>
</tbody>
</table>

Table 8. Chi square values for *Trichomonas vaginalis* with respect to age, symptoms and risk factors

<table>
<thead>
<tr>
<th>Factors considered</th>
<th>Chi square value ($\chi^2$)</th>
<th>P values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>19.888</td>
<td>0.000139</td>
</tr>
<tr>
<td>Symptoms</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>Risk factors</td>
<td>0.999</td>
<td>1.95708</td>
</tr>
</tbody>
</table>

A high prevalence of 24.50% was recorded amongst female students between the ages of 15-20 yrs. This prevalence rate correlates with the findings of Adinma et al. [32] who also recorded a high prevalence of 26.0% among pregnant women between the ages of 16-20yrs. The high prevalence among these young ladies is perhaps due to sexually activities or probably due to little or inadequate knowledge on how their vagina environment should be, hence a higher incidence of *G. vaginalis* infection. This supports the report by Adekanle et al. [33] who reported that pregnant women between the age group of 15-30 yrs were the most infected (100%) by one STD or the other.

A high prevalence of 9.7%, 10.5% and 0.9% in three states of Nigeria which include Ilorin, Ibadan and Calabar respectively. However, the prevalence is slightly lower than the findings of Nsagha et al. [29], Schwebke et al. [30] and Andrea et al. [31] who recorded prevalence rates of 41.0%, 53.0% and 41.3% in Cameroon, Nigeria and Rhode Island, USA respectively.

Although *G. vaginalis* is not necessarily called a sexually transmitted infection, it cannot be disputed that sexual activity can enhance its acquisition. Prevalence of positive individuals 35.61% symptomatic for *G. vaginalis* was higher than those asymptomatic 33.92%. This supports the general consensus that higher isolation rate of *G. vaginalis* occurs in symptomatic compared to asymptomatic women as reported by Adinma et al. [32].

Certain risk factors could enhance the rate at which *G. vaginalis* is transmitted or acquired. A high prevalence rate of 50.0% was recorded for those that smoke than those that douche. Although the number of those that douche was more than those that smoked, the high prevalence rate obtained from those that smoked...
backs up report by Hellberg et al. [34] that smoking increases the risk of acquiring bacterial vaginosis. The British Association for Sexual Health and HIV [35] reported that vaginal douching could disrupt vaginal environment and increase the number of anaerobic bacteria there, thereby allowing opportunistic infections to thrive.

The prevalence of *T. vaginalis* obtained in this study is 4.5%. This prevalence agrees with the separate findings of Mahmoud et al. [36], Isiaka-Lawal et al. [26] and Esthete et al. [37] who reported prevalence rates of 5.0%, 5.6%, 4.98% in Egypt, Nigeria and Ethiopia respectively. However, other studies in Nigeria demonstrated a higher prevalence of 13.67%, 17.5% in Zaria and Onitsha by Akafyi et al. [38] and Iwuezue et al. [39] recorded a lower prevalence of 1.2% in Yaounde, Cameroon Nsagha et al. [29]. The low prevalence of *T. vaginalis* infection observed in this study when compared to other studies may be partly explained by the difference in sensitivity of methods of diagnosis; microscopy rather than culture which has a comparatively high sensitivity and is considered as the gold standard. It may also be due to the difference in study population and hygienic practices as supported by Maufi et al. [40].

A prevalence rate of 4.0% for *T. vaginalis* was recorded among female students within the age group of 15-20 years. This supports the high prevalence of 71.4% reported among pregnant women between the age group of 15-20 yrs in a study conducted by Oyeyemi et al. [41]. However, Mahmoud et al. [36] and Iwuezue et al. [39] recorded high prevalence rates in ages 21-40 yrs and 30-39 yrs respectively.

In this study, symptoms acquisition was not significantly associated with *T. vaginalis* infection.

A prevalence rate of 0.67% was recorded for those that douched, smoked, and had one sexually transmitted infection and those that were sexually active. This supports the finding of [19] which states that smoking and sexual activity increases the risk of acquiring *T. vaginalis*. The coinfection of *Gardnerella vaginalis* and *Trichomonas vaginalis* in this study is 4.5%. This corresponds to the prevalence obtained for *Trichomonas vaginalis* alone. All the individuals that tested positive for *T. vaginalis* had *G. vaginalis*. This supports the findings of Piperaki et al [42] who reported that *G. vaginalis* was more frequent in women infected with *T. vaginalis*.

Bivariate analysis showing correlation coefficient results on Table 6 reveals that the factors considered in this study (age, symptoms and predisposing factors) had the following correlation coefficients 0.2065, 0.5863 and 0.4086 respectively. This result suggests that the factors considered have a moderate positive correlation as the Pearson’s correlation coefficient ranges from -1 to 1.

### 5. CONCLUSION

The result of this study reveals that the prevalence of *G. vaginalis* is relatively high compared to that of *T. vaginalis*. This supports the fact the replacement of vaginal lactobacilli with *Gardnerella vaginalis* is associated with bacterial vaginosis. On the other hand, *T. vaginalis* is a sexually transmitted disease which is acquired during unprotected sex. These infections can be eradicated or reduced by improved personal hygiene, abstinence from sex before marriage and adequate treatment. If left untreated these infections may cause untold damage to young ladies during pregnancy.

### CONSENT

All authors declare that ‘written informed consent was obtained from the patient (or other approved parties) for publication of this paper and accompanying images’.

### COMPETING INTERESTS

Authors have declared that no competing interests exist.

### REFERENCES


35. British Association for Sexual Health and HIV (BASHH). UK national guideline for the management of Trichomonas vaginalis infection; 2014.


37. Esthete A, Mekonnen Z, Zeynudin A. Trichomonas vaginalis infection among pregnant women in Jimma University Specialized Hospital, Southwest Ethiopia. Journal of Infectious Diseases; 2013. Article ID 485439. DOI: 10.1093/infdis/jit015


© 2016 Adogo et al.; This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.