Treatment options for vulvovaginal candidiasis: 1993

Authors' objectives
To critically evaluate published studies on the treatment of acute or recurrent vulvovaginal candidiasis in pregnant and non-pregnant women, and women infected with human immunodeficiency viurs (HIV).

Searching
MEDLINE was searched from 1974 to 1993; two books were reviewed for additional information.

Study selection
Study designs of evaluations included in the review
Randomised controlled trials and controlled trials were included.

Specific interventions included in the review
Anti-fungal agents for the treatment of vulvovaginal candidiasis (VVC). These were divided according to agents for topical therapy, oral therapy and intravaginal therapy.

The topical agents were clotrimazole, miconazole, tioconazole, butoconazole and terconazole.

The oral agents were itraconzole, ketoconazole and fluconazole.

The intravaginal agents were butoconazole, clotrimazole, miconazole, tioconazole and terconazole.

Participants included in the review
Pregnant and non-pregnant women with acute VVC. Women with recurrent VVC. HIV-infected women with acute or recurrent VVC.

Outcomes assessed in the review
Mycologic efficacy, defined as vaginal cultures negative for yeast at follow-up. Combined efficacy, defined as women lacking compatible signs and symptoms who had vaginal cultures negative for yeast.

How were decisions on the relevance of primary studies made?
The authors do not state how the papers were selected for the review, or how many of the authors performed the selection.

Assessment of study quality
The included studies were those which defined acute VVC as the presence of clinical signs together with vaginal swab cultures positive for yeast, and had a follow-up of greater than or equal to 25 days.

For the analysis of recurrent VVC, studies whose enrolment requirement included three or more clinically- and mycologically- documented episodes of VVC within the preceding twelve months were considered. The authors do not state how the papers were assessed for validity, or how many of the authors performed the validity assessment.

Data extraction
The authors do not state how the data were extracted for the review, or how many of the authors performed the data extraction.
**Methods of synthesis**

How were the studies combined?
The studies were combined in a narrative review and table summaries, where studies were grouped by problem (acute or recurrent), by patient (non-pregnant, pregnant) or HIV-infected women.

How were differences between studies investigated?
The authors do not state how differences between the studies were investigated.

**Results of the review**

There were 26 studies of topical therapy for non-pregnant women,

15 studies of oral therapy for acute VVC in non-pregnant women,

6 studies of topical therapy for pregnant women,

5 studies of therapy for recurrent VVC in non-pregnant women, and

0 studies of treatment for recurrent VVC in HIV infected women.

The optimal treatment for recurrent VVC has not yet been established. Topical therapy with clotrimazole for recurrent VVC caused no toxicity, but was followed more often by relapses. No studies evaluating treatment options for recurrent VVC in HIV-infected women have been published.

Toxicity of drugs used in the treatment of VVC:

Topical treatments were shown to have few side-effects, whereas oral treatments can be associated with some gastrointestinal symptoms and headaches. Clinically important interactions may occur if taken with other drugs.

Trials have found the topical imidazole antifungal agents clotrimazole, micinazole and butoconazole to be effective for the treatment of acute VVC in pregnant women. Terconazole has been studied in Europe and has been found to be effective and safe. The efficacy of nystatin ranged from 14 to 53%; this was considerably lower than that of the topical azoles, which ranged from 71 to 84%.

Oral therapy is approximately as effective as topical therapy in non-pregnant women. The optimal treatment for recurrent VVC in non-pregnant women has not been established yet.

In comparative trials of topical treatment for acute VVC in non-pregnant women the azoles (clotrimazole and miconazole) resulted in higher rates of clinical and mycologic cure (80-95%) than nystatin (70%-90%).

**Cost information**

The cost of each treatment was given in dollars.

**Authors’ conclusions**

For acute episodes of VVC in non-pregnant women, topical or oral antifungal agents were clinically and mycologically effective. Topical agents are the first-line of therapy but oral agents are sometimes associated with better compliance.

For acute episodes in pregnant women, a topical agent is the treatment of choice. Until data become available on the treatment of VVC in women infected with HIV, the same approach as that used without HIV should be considered. For recurrent VVC, the optimal maintenance therapy has not been established; however, low-dose oral ketoconazole has proven effective.

Well-designed studies of best therapy for VVC in women with HIV infection and recurrent VVC are urgently needed.
CRD commentary
It is unclear how the different studies were weighted as to the quality of evidence. The treatments reviewed were those available in the US; they may not be available in the UK.

Implications of the review for practice and research
Well-designed studies of best therapy for VVC in women with HIV infection and recurrent VVC are urgently needed.

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