Journal Club


Uncomplicated isolated episodes of vulvovaginal candidiasis (VVC) affect most women at some point in their lives, with almost half experiencing two or more episodes.1 Topical vaginal, oral single-dose, or short-course azole therapy is usually effective in this situation.2,3 Recurrent VVC (R-VVC) is much less common, affecting around 5% of women. As pointed out in Eschenbach’s editorial,3 this accounts for many medical consultations in women of all ages who suffer the miserable symptoms of recurrent vulval itching and soreness, vaginal discharge, or associated dyspareunia. Despite the unpleasant symptoms, VVC is not a cause of substantial mortality4,5 or morbidity, and so is an understudied and poorly understood, and it follows from this that management is not evidence-based.

In this paper, Sobel and colleagues evaluate an open-label induction programme (three oral doses of 150 mg fluconazole 1 day apart; 2 weeks later by randomisation to either monthly oral 150 mg fluconazole or placebo) in 6 months. The patients enrolled had severe symptoms of R-VVC of more than 1 year’s duration. The patients were randomised to fluconazole and placebo groups. A total of 137 patients were included in the fluconazole group and 137 in the placebo group. The patients were followed up for a further 6 months. The patients enrolled had severe symptoms of mycologically proven recurrent VVC with acute vulval and vaginal lesions and four documented episodes in the previous year. Exclusion criteria included the known risk factors for R-VVC of pregnancy (also a contraindication for oral contraception), HIV infection, or diabetes, and so on. The patients were randomised into the fluconazole and placebo groups, then a second randomisation in the treatment arm did significantly better, with 90.8% recurrence free at 6 months compared to 35.9% in the placebo arm. The study included 342 patients, of which 279 were women with a BMI>30, and 72 women with a BMI>30 had higher cholesterol levels. These might predict an increased risk of VTE. A total of 205 VTE-like events were self-reported, but 163 of these events were not confirmed. Forty-two cases were confirmed as a definite VTE by imaging, or as a probable VTE by a non-imaging or clinical diagnosis. There were no significant differences between the two groups in the interim results (at 3 years). The review also points out that the rate of thrombotic events has previously been found to be higher in the first year of use of COCs and in people switching from one type to another. Trends for R-VVC were similar to those found for other COCs. Obese women (BMI>30) had a much higher risk of VTE than women with a BMI<30. The review concluded that these interim results from the EURAS Study do not suggest that users of EE/DDSP or other oral contraceptives (OCs) are at increased risk of VTE compared to other users of OCs. There is a theoretical potential for hyponatraemia to develop in some women who take an oral formulation containing DRSP, putting women at high risk of arrhythmia. The clinical trials on EE/DDSP clearly show that no significant hyponatraemia. Fifteen cases of raised levels of potassium have been reported in postmarketing surveillance but none of the levels were high enough for a risk of arrhythmia. The interim results from the EURAS Study showed no difference in rates of arrhythmia between the cohorts. No increased risks of psychiatric conditions, fatalities or birth defects following the use of EE/DDSP were unrecorded by the review. The results from the EURAS Study may give rise to concern in that the incidence of VTE in all the cohorts of OC users was higher than has previously been reported for COCs.

However, it is notoriously difficult to establish true baseline rates for VTE as many minor thrombotic events remain unreported and undiagnosed. Sobel and colleagues state: “The difficulty in establishing a true rate for long-haul travel is a case in point. The increased case of diagnosis using d-imer testing and the greater availability of imaging may help to establish more accurate current base rates for comparison in the future.” The small absolute risks of VTE must be considered relative to other risks, such as road traffic accidents, that women in these age groups run.

The recent issue of the report from the Medicines and Healthcare products Regulatory Agency (MHRA) also comments on the early reports of higher numbers of episodes of VTE in women of Yasmin. This report from the Committee for Safety of Medicines points out that these early reports were derived from non-comparative data. The article concludes that prescriptions should be bear in mind that:

- the interim results from comparative studies suggest that the rates in users of Yasmin do not appear to differ from those in users of other OCs.
- OCs should be prescribed with caution in postmenopausal women at risk of thrombotic events.
- patients should be advised to consult their GP if they notice any symptoms of thromboembolism.


Patients between the ages of 18 and 25 years completed a self-administered and confidential questionnaire in the waiting room of 20 participating practices before seeing a family practitioner for routine consultations. The patients were randomised to receive usual care (the control group) or brief advice about safe sex, human immunodeficiency virus and hepatitis (the intervention group). Three months later, the patients were asked by post to complete a follow-up questionnaire, with a BM3-30 or with a predispension to VTE.

The results did not show that a brief intervention in a routine consultation improved knowledge about risk or changed risk behaviour. Given the competing demands on time in any consultation, this may not be a useful investment. It would seem to me that interventions are better targeted on the consultations where sexual activity is a natural part of the consultation.

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References