Recurrent Vulvovaginal Candidiasis

Vulvovaginal candidiasis is very common with around 75% of women estimated to have at least one episode in their lifetime and 40-50% experiencing at least one recurrence. It is estimated 5% of women will experience Recurrent Candidiasis. (US Centre for Disease Control, 2015).

Up to 20% of women of reproductive age may be colonised with asymptomatic species not requiring treatment (RCGP 2019). Treatments only required in those patients who have symptoms.

Recurrent Candidiasis is defined as:

- **4 or more episodes** of vulvovaginal candidiasis in a year
- At least 2 of these episodes must be confirmed on microscopy or culture when symptomatic with at least one confirmed on culture.

Confirming the diagnosis of recurrent vulvovaginal candidiasis

- Send swab stating **"Recurrent Candidiasis for Candida ID and Sensitivities"** on request (please note that Details of recurrent candida will not otherwise be processed for ID and sensitivities)
- Candida albicans accounts for the vast majority of cases. However, there are many other species of candida that can cause candidiasis some of which are more likely to be resistant to standard first line treatments, so candida ID and sensitivities are important to guide future treatment.

Risk Factors for Recurrent Candidiasis

For some patients there will be no identifiable risk factor or trigger.
Advise patients on the following risk factors as modification of these may help prevent recurrent episodes:

- Recent antibiotic use
- Poor adherence to treatment
- Local irritants e.g. soaps/shower gels/douching
- Poorly controlled Diabetes Mellitus
- Immunosuppression e.g. HIV, Long-term corticosteroids
- Endogenous or exogenous oestrogens e.g. pregnancy, COCP, HRT. Low dose oestrogen COCP may be preferable to high dose oestrogen COCP but progesterone only contraceptives are generally preferable in particular Depo-Provera especially in those with cyclical recurrence.

Treatment

NICE Guidelines and BASHH Guidelines recommend:
Manage any co-existing vulval dermatitis.

- Treat current episode (induction therapy) with fluconazole 150 mg orally on day 1, day 4, and day 7). Then for maintenance therapy prescribe Fluconazole 150mg Once a week for 6 months.
  Be mindful of the potential for fluconazole to interact with other drugs and prolong the QT interval
- **If ORAL Azoles are contraindicated or not tolerated e.g. pregnancy, breastfeeding:**
  - Induction therapy: Clotrimazole 500mg pessary nightly for 10-14 days followed by
  - Maintenance therapy: Clotrimazole 500mg nightly once weekly for 6 months

A topical azole cream can be used in conjunction with the above treatments if vulva symptoms are particularly troublesome.

If maintenance treatment is successful but symptoms relapse after 6 months of suppression ends then maintenance can be continued beyond this.

Treatment Failure

- If a patient relapses between doses during maintenance treatment consider twice weekly fluconazole. Alternatively, a trial of cetirizine 10mg OD can be considered to help with itch. Emollients may be helpful if there is co-existing evidence of dermatitis and only partial response to treatment.
- For patients with poor response to therapy or only a partial response to therapy or in those rare cases where candida is resistant to Azole treatment on sensitivity testing the only licenced option is Nystatin vaginal pessary 100,000units given intra-vaginally at night for 14 consecutive days.
- *Consider seeking advice or referral to Sexual Health who can be helpful in the management of difficult cases.*

Do asymptomatic male sexual partners of women with vulvovaginal candidiasis require treatment?
No, asymptomatic male partners do not require treatment for candidiasis. Only consider treatment if they are symptomatic there is clinical evidence of candidal balanitis.

References

1. NICE Guidelines -Candida Female Genital https://cks.nice.org.uk/topics/candida-female-genital/
2. BASSH Guidelines for the Management of Vulvovaginal Candidiasis 2019 https://www.bashhguidelines.org/media/1223/vvc-2019.pdf