NHS FORTH VALLEY

Management of Recurrent Vulvovaginal Candidiasis (Adults)

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1. Introduction

Vulvovaginal candidiasis (VVC), also known also as genital thrush, is a condition that can affect women, transmen and non-binary people with a vagina of any age.

Briefly, the disease is characterised by a symptomatic inflammation of the vagina and/or the vulva caused by a superficial fungal infection. This causes vulval discomfort, including itch, and non-offensive vaginal discharge. Other symptoms can include soreness, burning, and dyspareunia.
Patients presenting with these symptoms presenting with features suggesting recurrent VVC should always have a clinical examination to exclude alternative or co-existing vulvovaginal pathologies.
VVC can be divided into acute and recurrent. Acute VVC are often first or isolated presentations of the above. Self-management strategies coupled with over the counter treatment (sometimes via the chemist) resolves most cases, often with single dose therapy.

By contrast, recurrent VVC (or rVVC) is defined as at least four episodes per 12 months with two episodes confirmed by microscopy **or** culture when symptomatic. Treatment is typically much longer, lasting in the region of six months.

This guidance is aimed at patients aged 16 and over presenting with rVVC. Clinicians are advised to refer to CKS (Clinical Knowledge Summaries) and BASHH (British Association for Sexual Health and HIV) management of vulvovaginal candidiasis guidance for further details of **self-management measures** that patients can be advised to take in addition to any therapies described below. Those with poor glycaemic control should be encouraged to improve this.

Links to guidance

Candida - female genital | Health topics A to Z | CKS | NICE

British Association for Sexual Health and HIV national guideline for the management of vulvovaginal candidiasis (2019)

2. Lab Process Summary

Submit a blue-top charcoal swab to the NHS Forth Valley microbiology for MC&S (Microscopy Culture and Sensitivity) when investigating rVVC. In the clinical detail, please indicate ‘VVC or rVVC’ depending on the diagnosis. Results can take up to 3 days once receipted in the laboratory.

3. Proposed Empirical Treatment algorithm Recurrent VVC following BASHH VVC Guidelines

Given the stability of sensitivity patterns among Candida species and limitations with automated sensitivity testing for Candida species the laboratory, the microbiology service is moving to an identification-only approach for most cases of rVVC. This means sensitivity results will not be issued unless requested by a GUM or Gynae consultant. Instead, a clinical comment will accompany all laboratory reports based on the identification of the Candida species. Each comment will provide several options for clinicians to prescribe. Prescribers should choose the treatment that best suits the patient based on their previous rVVC treatments (if any), pregnancy and/or breast feeding status, allergy status.

This guidance categorises Candida spp into three types based on their likely susceptibility to fluconazole.

Category A Candida species are usually, if not always, sensitive to fluconazole therapy. While resistance is possible, it is rare. If a patient has attempted fluconazole therapy without success, or is contraindicated, then other agents can be prescribed empirically including clotrimazole, boric acid OR nystatin therapy.

Category B Candida species may respond to higher doses of fluconazole therapy but therapy may still fail as these isolates have higher levels of inherent resistance to fluconazole. If a patient has attempted fluconazole therapy without success, or is contraindicated, then other agents can be prescribed empirically including clotrimazole, boric acid OR nystatin therapy.

Category C Candida species are resistant to fluconazole and another treatment is advised. If no contraindications prescribers can consider clotrimazole, nystatin, or boric acid treatments. GUM or Gynae consultants in hospital settings may consider amphotericin B suppository therapy as this agent is more challenging to access in primary care. Amphotericin B suppository therapy is a restricted item and is for specialist initiation only.

Table 1. ID Candida by MALDI and issue report with associated comment

Category	A	B	C
Organism	C albicans C dubliniensis C tropicalis S cerevisiae C parapsilosis C lusitaniae C kefyr	C glabrata C guilliermondii	C krusei C auris*
Associated comment	Although not tested this organism is usually sensitive to Fluconazole. Be aware of 1-week washout period after fluconazole before getting pregnant. If intolerant, or treatment failure consider clotrimazole, boric acid OR nystatin therapy. Do NOT use Fluconazole, boric acid if pregnant or breastfeeding.	Although not tested this organism may respond to higher doses of Fluconazole but treatment failure is likely. Be aware of 1-week washout period after fluconazole before getting pregnant. If intolerant, or treatment failure consider clotrimazole, boric acid OR nystatin therapy. Do NOT use boric acid if pregnant or breastfeeding.	Although not tested this organism is likely to be resistant to Fluconazole. Consider clotrimazole, nystatin, or boric acid. GUM or Gynae consultants may consider amphotericin B suppository therapy. Do NOT use boric acid if pregnant or breastfeeding. * Enhanced infection control measures must be taken when accessing healthcare or in hospital. Complicated C auris cases should always be discussed with an infection specialist.

Table 1 notes

1. Sensitivity testing on any Candida isolate can be requested by O&G, GUM or Infection Consultant if email request sent to **fv.microbiology@nhs.scot** inbox with sample details with 5 days of the report being issued.

2. If the microbiology laboratory identifies resistance based on above then the following referral rules are in place within the laboratory:

Lab Referral guidelines to Bristol for further sensitivity testing:

Category A: If resistance to fluconazole and/or Amphotericin B on Vitek2

Category B/C: If resistant to Amphotericin B on Vitek2

Special Note: All C auris should be sent for confirmation and susceptibility testing. All referred isolates should also be stored

Clinicians, please take note of the following before prescribing:

1. Growth of yeast from any superficial or vaginal swab likely represents colonisation in the absence of clinical signs and symptoms of VVC; it is not in itself a diagnosis of VVC or rVVC. Please ensure you have examined the patient and made the diagnosis before embarking on treatment.

2. Review BASHH Vulvovaginal Candidiasis guidelines for latest evidence based management guidance including self-management interventions that should be used in conjunction with antifungal therapy.
3. Women with immunocompromising conditions, receiving regular steroid treatment or with poorly controlled diabetes may require specialist sexual health (GUM) or gynaecological input in recurrent VVC.
4. **Women with severe VVC/rVVC** should be referred to a specialist in sexual health (GUM) or gynaecology (consider patient preference) for urgent review and treatment. Please reference if **first, second and/or third line** empirical therapy has been issued and if it has had any positive effect or failed. Full history of treatment should be included clearly on the referral with names and dates of treatments used. Referral information is available on MARG and is the same for both GUM and Gynaecology.
5. **Pregnant/Breastfeeding**: Avoid oral fluconazole and boric acid; preferentially choose an appropriate topical/pessary therapy.
6. Boric and Nystatin pessaries are unlicensed and as such may take 5-7 days for most community pharmacies to acquire the treatments. Please inform the patient of this delay.
7. Fluconazole resistance in normally-susceptible Candida species is rare. The microbiology laboratory can test isolates within 5 days of an issued report on the advice of a GUM, O&G or an infection specialist (microbiology or ID) only after all empirical therapy options have failed. Email the laboratory with patient details along with the report number to fv.microbiology@nhs.scot.
8. Review the need for contraception based on therapy advised/prescribed.
   Boric acid and clotrimazole – latex condoms and diaphragms can be damaged by these agents.
   Boric acid may reduce efficacy of vaginal spermicides.

Prescribing for Category A Isolates – Organisms usually susceptible to Fluconazole

1st Line	Fluconazole	Induction: Fluconazole 150 mg orally every 72h x 3 doses Maintenance: Fluconazole 150 mg orally once a week for six months *AVOID IN PREGNANCY/BREASTFEEDING
2nd Line	Clotrimazole	Induction: 500mg pessary daily for 14 days Maintenance: Clotrimazole pessary 500 mg intravaginally once a week for 6 months
3rd Line	Nystatin OR Boric Acid	Nystatin pessaries 100,000 units PV nocte for 14 nights per month for six months OR Boric acid vaginal suppositories 600 mg daily for 14 days per month for 6 months **AVOID IN PREGNANCY OR RISK OF PREGNANCY

Note about Fluconazole failure in normally susceptible isolates

Fluconazole: What if some improvement is noted but falls short of complete resolution?
If the patient has a Category A isolate that is usually susceptible to fluconazole and has only experience some improvement in symptoms over a few months of use it may necessitate moving to a second or third line agent. This is because fluconazole is not as effective in your patient. Assuming adherence to the prescription is optimal and other lifestyle factors listed in BASHH VVC guidelines are reviewed and self-management strategies optimised it could be down to factors to do with the treatment itself. Sometimes

vaginal pH can influence the activity of fluconazole. It might also be that the isolate is resistant to fluconazole and therefore moving to the next line agent is likely to be more effective. Finally, recurrently VVC may be polymicrobial and the initially sensitive organisms are removed, leaving more resistant organisms behind. As the microbiology laboratory cannot test the sensitivity of alternative agents it is reasonable to progress to the next line of therapy where therapeutic benefit has plateaued.

Prescribing for Category B/C Isolates – Organisms likely to fail Fluconazole therapy

1st Line	Clotrimazole	Induction: Clotrimazole pessary 500mg pessary daily for 14 days Maintenance: Clotrimazole pessary 500 mg intravaginally once a week for 6 months
2nd Line	Nystatin OR Boric acid	Nystatin pessaries 100,000 units PV nocte for 14 nights per month for six months OR Boric acid vaginal suppositories 600 mg daily for 14 days per month for 6 months **AVOID IN PREGNANCY OR RISK OF PREGNANCY

References

British Association for Sexual Health and HIV national guideline for the management of vulvovaginal candidiasis (2019) International Journal of STD & AIDS 2020, Vol. 31(12) 1124–1144 https://www.bashh.org/resources/guidelines

Clinical Knowledge Summaries Candida - female genital | Health topics A to Z | CKS | NICE

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