Treatment of Vulval Candidiasis with 5-Fluorocytosine

SIR,—The interesting report by Mr. S. A. Seligman (20 July, p. 173) raises once again the important question of the use of valuable systemic antimicrobial drugs in the treatment of relatively trivial topical infections. He very rightly points out that severe candidiasis of the female genitalia can have wide-ranging effects on the patient and on her marital and family happiness. 5-Fluorocytosine is, however, an extremely effective drug in life-threatening systemic candidiasis, particularly when associated with organ transplant and cardiac prosthetic surgery, though it must be recognized that not all "wild" strains of yeast-like fungi are sensitive to it. The drug has only one major disadvantage; in several instances where patients were receiving adequate dosage mutants of candida and cryptococci virtually resistant to 5-fluorocytosine have dramatically appeared within a few days of starting treatment.¹ This is a grave and alarming situation usually demanding reluctant recourse to systemic amphotericin B.

Many of us remember only too well the disastrous upsurge of benzylpenicillin-resistant staphylococci in the late 1940s and the 1950s after the indiscriminate use of that antibiotic. There is a considerable likelihood that the topical use of 5-fluorocytosine may similarly induce a great increase in the number of candida strains with enhanced resistance to it and the drug could thus lose much of its therapeutic value in severe systemic mycoses. For this reason the report by Grigoriu and Grigoriu² in Athens last year on the use of 5-fluorocytosine for the treatment of cutaneous candidiasis met with considerable criticism.

The use of the topical and possibly the oral preparations of either of the new imidazole derivatives, clotrimazole and miconazole, now available might well have been preferable in this case. These drugs are also valuable in the therapy of systemic mycoses, but they seem not to throw up resistant mutants during *in vitro* studies or in clinical use.³ A high proportion of women with vaginal candidiasis carry a reservoir of the same strain of candida in their faeces,⁴ which if not eliminated by oral antimycotic therapy can readily originate vaginal reinfection. Mr. Seligman does not mention whether his patient had positive faecal cultures, and in so persistent an infection as this she may in fact have had both faecal and genital reservoirs, with cyclic reinfection. If so, these were presumably eliminated by her course of 5-fluorocytosine, because she remained culturally negative and symptom-free for nine months. Possibly her mild abdominal discomfort for a month resulted from considerable ecological changes in her faecal flora.—I am, etc.,

R. J. HOLT

Microbiology Department,
Queen Mary's Hospital for Children,
Carshalton, Surrey

¹ Holt, R. J., and Newman, R. L., *Journal of Clinical Pathology*, 1973, 26, 167.
² Grigoriu, A., and Grigoriu, D., *Abstracts, 8th International Congress of Chemotherapy, Athens, 1973*, A.431.

³ Holt, R. J., *Infection*, 1974, 2, 96.

⁴ Wheatley, D., *Abstracts, 8th International Congress of Chemotherapy, Athens, 1973*, A.429.

Idoxuridine in Herpes Zoster

SIR,—Dr. H. Davies (6 July, p. 41) referred to the absence of pain as a symptom of

zoster in younger patients. Like Dr. R. Dawber (8 June, p. 526), I studied a series of patients with this disease whom I treated with idoxuridine in dimethyl sulphoxide (DMSO). Of 50 patients entered to the trial 36 were aged between 50 and 80, but the series did include a number of young people, including two children aged 7. Only three of the 50 patients had no complaint of pain before treatment, and it was interesting that pain preceded the appearance of the rash by an average interval of 2.9 days in 35 patients in the series. There was rapid and marked diminution in pain after one week in nearly half the patients and by the end of the third week only 10 patients had failed to experience significant pain relief.

Dr. Davies asked about the segmental distribution of the lesions in Dr. Dawber's series. He may be interested in the distribution in my series (see fig.), which is similar to that reported by Hope-Simpson¹ in his Gloucestershire practice.

Professor B. E. Juel-Jenson and Dr. F. O. MacCallum (6 July, p. 41) reported significant superiority in therapeutic effect of topical 40% idoxuridine in DMSO over 5% idoxuridine in DMSO in patients with zoster. Their comparison related to treatment by continuous application to the whole affected dermatome. Adopting the more economical technique used by Dr. Dawber, four-times daily application solely to the skin lesions, I found no significant difference in therapeutic response to 40% and 5% idoxuridine in DMSO in 50 patients randomly allocated to double-blind treatment with one of these concentrations. One patient suffered acute local skin sensitization and showed a positive reaction to patch testing with idoxuridine 5% and 1% in DMSO but not with DMSO alone. Nine-

teen patients complained of slight stinging from the DMSO and 10 (all in the 40% idoxuridine group) of severe stinging.—I am, etc.,

J. R. SIMPSON

Department of Dermatology,
Royal Devon and Exeter Hospital,
Exeter

¹ Hope-Simpson, R. E., *Update*, 1973, 7, 1725.

Swimmers' Ears

SIR,—You advise (27 July, p. 213) on the prevention of otitis externa with particular reference to underwater swimmers and scuba diving. We believe that your advice is potentially harmful. The use of any ear plug in diving is contraindicated. The air trapped beyond the plug will be compressed during descent in accordance with Boyle's law and the plug will therefore be forced further into the meatus, not necessarily reversibly. A tight-fitting plug might lead to "reversed ear," a form of barotrauma which was first described in your pages.¹

Prophylaxis is particularly important in divers who, in saturation diving, make several dives daily for several days to great depths and in whom the subsequent decompression to atmospheric pressure takes several more days in an atmosphere with an unavoidably high humidity. Prevention of otitis externa in these men has been achieved by the intermittent application of aluminium acetate and 2% salicylic acid in 60% rectified spirit or tincture hydrargaphen (taking care to avoid build up of hard aluminium acetate products in the meatus).² In the macerated epithelium often associated with frequent diving and high humidity in the tropics fungal infections with aspergillus or candida are often overlooked. Treatment of only Gram-negative or Gram-positive organisms in such cases leads to the well-known high recurrence rate of otitis externa. For many years it has been Naval practice to assume both types of infection are present (in the absence of laboratory control). The follow-up therapy of 2% salicylic acid instilled once weekly for two months has proved most effective in desquamating epithelium which may still harbour fungal elements. No cases of undue drying of the meatal skin have been recorded in many hundreds of treatments. A significant association of otitis externa and seborrhoea capitis epidermophytosis has been noted and these require treatment at the same time.—We are, etc.,

D. H. ELLIOTT

Institute of Naval Medicine,
Alverstoke, Gosport,

P. W. HEAD

E.N.T. Department
R.N. Hospital, Haslar

¹ Jarrett, A. S., *British Medical Journal*, 1961, 2, 483.

² Head, P. W., *Practitioner*, 1973, 211, 738.

Drugs for Gastric Ulceration

SIR,—I agree with Sir Francis Avery Jones (3 August, p. 342) that my comment (20 July, p. 169) "carefully conducted Scandinavian trial which showed no demonstrable effect," refers to deglycyrrhizinized liquorice and not to carbenoxolone, and I apologize for a genuine error. The study reported by Fung *et al.*¹ was with carbenoxolone sodium, and these authors concluded that "carbenoxolone sodium has no beneficial effect in