Topical Antifungals: Some Oldies Are Still Goodies

BY BRUCE JANCIN

Denver Bureau

MAUI, HAWAII — The newer topical antifungals have essentially the same cure rates as do those available since the 1970s—their advantage is that they work faster, Dr. Douglas W. Kress said at the annual Hawaii Dermatology seminar sponsored by Skin Disease Education Foundation.

"I think all the agents—the azoles, allylamines, benzylamines, and ciclopirox—are going to work fairly well if you make a good choice for what you're trying to treat.

"All of these things have cure rates of about 70%-80%," explained Dr. Kress, chief of the dermatology service at the Children's Hospital of Pittsburgh.

He provided a quick tour of the four major classes of antifungal agents that are available, from oldest to newest:

► **Polyenes.** Nystatin is approved solely for treatment of yeast infections.

"The pediatricians in western Pennsylvania love nystatin, but I see a tremendous amount of nystatin failure, so this is not an agent that I use in my practice," he said.

► **Azoles.** These have broad spectrums of action. "If you're not sure if you're dealing with a dermatophyte or yeast, something in the azole class is probably the treatment of choice," he continued.

Options include econazole, ketoconazole, oxiconazole, and sulconazole. Clotrimazole and miconazole remain effective but have the practical drawback of being over the counter.

"If patients have waited as long as they have for an appointment with us and then see us for the very short amount of time we can give them, [giving them] an OTC antifungal is not how we want to practice," Dr. Kress said.

He singled out oxiconazole, the first topical antifungal approved for once-daily use, as particularly useful.

"When I give it to patients I recommend twice-daily use knowing they're probably going to use it once a day. It's nice to know that, at least with oxiconazole, once a day is going to be as effective," he observed.

Also, oxiconazole is available in a lotion, which is especially helpful in tough cases of tinea pedis.

"It's really difficult to get a cream to spread between the toes well," Dr. Kress said. "The trick I give people is to have them put a drop of the lotion between each web space and use a Q-tip to spread it between the toes. It's almost the equivalent of dental flossing between your toes. It works really well in clearing that reservoir in the fourth web space."

Econazole is unique among the azoles in that published studies show it has antibacterial properties, he noted.

► **Allylamines and benzylamines.** All three drugs in this class—naftifine, terbinafine, and butenafine—are expensive and dramatically more effective for dermatophytes than for yeasts.

"I do not recommend their use in yeasts. The azoles are much better," Dr. Kress said.

Butenafine is now available over the counter. "That's probably your biggest gun today if you need to make an OTC recommendation," he suggested.

In a randomized double-blind trial comparing newer and older therapies, 80 patients with tinea cruris or tinea corporis were placed on once-daily 1% butenafine for 2 weeks or 1% clotrimazole b.i.d. for 4 weeks.

The 27% clinical cure rate at 1 week with butenafine was ninefold greater than clotrimazole's 3%. The mycologic cure rate at 2 weeks was 62% with butenafine and 18% with clotrimazole. By 4 weeks, however, cure rates in the two groups were not significantly different (J. Dermatolog. Treat. 2005;16:331-5).

The key lesson: "If you're willing to be a little more patient, some of the azoles are very effective," Dr. Kress commented.

► **Ciclopirox.** Available in gel and lotion formulations with equally good efficacy against dermatophytes and yeasts, as well as in a shampoo for seborrheic dermatitis.

Ciclopirox is also available as a nail lacquer for treatment of onychomycosis. Dr. Kress called it a "terrible" product.

"The numbers in the package insert cite a less than 12% cure rate. I don't know how that got by the [Food and Drug Administration]. Really, you need an oral agent," he said.

Dr. Kress had no disclosures pertaining to this presentation.

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Oddly enough, the way they describe their GERD may be why it's often overlooked.

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• PREVACID use in this population is supported by evidence from adequate and well-controlled studies in adults along with additional clinical and PK/PD studies performed in pediatric patients. The pediatric studies were uncontrolled, open-label studies performed in 66 patients aged 1 to 11 years old and 87 patients aged 12 to 17 years old. The safety and effectiveness of PREVACID have not been established in patients <1 year of age.

• The most frequently reported adverse events in patients aged 1 to 11 years were constipation (5%) and headache (3%).

In patients aged 12 to 17 years, the most frequently reported adverse events were headache (7%), abdominal pain (5%), nausea (3%), and dizziness (3%). The adverse event profile in children and adolescents resembled that of adults taking PREVACID, where the most common adverse events were diarrhea (3.8%), abdominal pain (2.1%), and nausea (1.3%). Symptomatic response to therapy does not preclude the presence of gastric malignancy. PREVACID formulations are contraindicated in patients with known hypersensitivity to any component of the formulation.

Individual results may vary.

See adjacent page for brief summary of prescribing information.

*Based on IMS Health Xponent® data, December 2005.

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References 1. Rudolph CD, Mazur LJ, Liptak GS, et al. *J Pediatr Gastroenterol Nutr.* 2001;32(suppl 2):S1-S31. 2. Data on file, TAP Pharmaceutical Products Inc. 3. PREVACID Complete Prescribing Information. 4. Aciphex® (rabeprazole sodium) Complete Prescribing Information. 5. Nexium® (esomeprazole magnesium) Complete Prescribing Information. 6. Prilosec® (omeprazole) Complete Prescribing Information. 7. Protonix® (pantoprazole sodium) Complete Prescribing Information. 8. Zegerid™ (omeprazole) Complete Prescribing Information.

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