Topical Antifungals: Some Oldies Are Still Goodies

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MAUI, HAWAII — Newer topical antifungals have essentially the same cure rates as 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.

"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%," said Dr. Kress, chief of the dermatology service at the Children's Hospital of Pittsburgh.

He overviewed the four major classes of antifungal agents, from oldest to newest:

▶ **Polyenes.** Nystatin is approved solely for treatment of yeast infections. Though Dr. Kress said that his colleagues frequently prescibe it, he added that " I see a tremendous amount of nystatin failure, so this is not an agent that I use in my practice."

▶ **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.

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DR. KRESS

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 helpful in tinea pedis cases.

"It's really difficult to get a cream to spread between the toes well," Dr. Kress said. "Have [patients] put a drop of the lotion between each web space and use a Q-tip to spread it between the toes."

Econazole is unique among azoles in that 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 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 lesson: "If you're willing to be a little more patient, some of the azoles are very effective," Dr. Kress said.

▶ **Ciclopirox.** This is available in gel and lotion formulations with equally good efficacy against dermatophytes and yeasts, as well as in a shampoo for seborrheic dermatitis. It 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. Really, you need an oral agent," he said.

Dr. Kress had no disclosures pertaining to this presentation.

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