

# Topical Antifungals: Some Oldies Are Still Goodies

BY BRUCE JANCIN  
Denver Bureau

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 prescribe 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.



**‘I see a tremendous amount of nystatin failure, so this is not an agent that I use in my practice.’**

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 ef-

ficacy 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.

SDEF and this news organization are wholly owned subsidiaries of Elsevier. ■

## ADVERTISEMENT

### Millions of American men suffer from symptomatic BPH.<sup>1-3</sup> And many remain undiagnosed.

Benign prostatic hyperplasia (BPH), also known as an enlarged prostate, can lead to restricted urine flow. Of the 20 million American men who have symptomatic BPH, only 5 million have been diagnosed.

Symptoms of BPH include:

- Frequent urination during the day and night
- Difficulty starting urination
- A weak and/or interrupted urine stream
- Inability to completely empty the bladder

While in most men these symptoms are caused by BPH, it is important to rule out prostate cancer as part of the diagnostic process.

#### Who is at risk for BPH?

Men over the age of 40 are primarily at risk for BPH.<sup>4</sup>

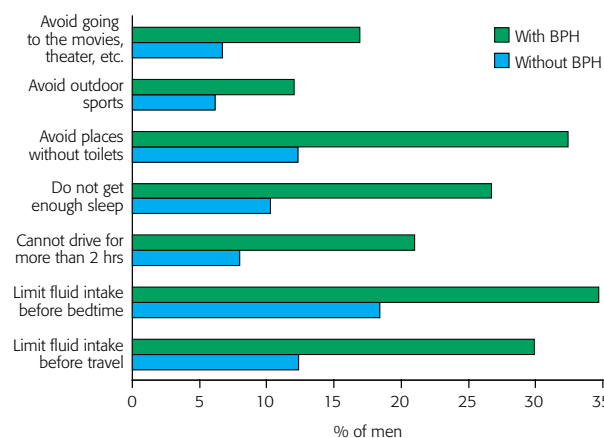
Age	% exhibiting symptoms of BPH
40 to 50	27
51 to 60	50
61 to 70	69
71 to 80	79

Unfortunately, the vast majority of men with BPH suffer in silence, often due to their embarrassment broaching the subject with their physicians or because they assume it is simply part of aging and that nothing can be done about it.

#### BPH can have a major impact on their lifestyle

Men with symptomatic BPH report disruptions in their lifestyle. BPH can create anxiety, interfere with routine activities and leisure pursuits, limit sexual activity, and cause sleep deprivation.<sup>5</sup>

#### % of men whose daily living was affected at least some of the time\*



BPH can also have an impact on the partners of men with BPH. One survey found that 86% of partners experience a lifestyle disruption. Forty-one percent were regularly awakened by their husbands’ frequent urination at night.<sup>6</sup>

The symptoms caused by BPH can be managed. But first, the patient must overcome his reluctance to discuss the topic with his physician.

By using probing questions like the ones below, physicians can initiate a successful conversation about BPH.<sup>3,7</sup>

- Do you get up several times at night to urinate?
- Do you find it difficult to hold off urination?
- Do you have difficulty starting urination?

Once BPH has been diagnosed, the physician can then determine the best course of treatment.

#### Treatment options

Standard treatment options for BPH include watchful waiting, medical therapy with alpha blockers and/or 5-ARI inhibitors, and various surgical procedures. Treatment is typically driven by both the severity of symptoms and patient perception of lifestyle disruptions.

#### References:

1. Decision Resources Patient Base, July 18, 2006.
2. Daly MP. Quality of life in sexually active men with symptomatic benign prostatic hyperplasia. *Clin Drug Invest.* 2005;25:219-230.
3. Garraway WM, Russell EB, Lee RJ, et al. Impact of previously unrecognized benign hyperplasia on the daily activities of middle-aged and elderly men. *Br J Gen Pract.* 1993;43:318-321.
4. Guess HA, Arrighi HM, Metter EJ, Fozard JL. Cumulative prevalence of prostatism matches the autopsy prevalence of benign prostatic hyperplasia. *Prostate.* 1990;17:241-246.
5. McVay KT. *Am J Manag Care.* 2006;12(suppl):S122-S128.
6. Shvartzman P, Borkan JM, Stoliar L, et al. Second-hand prostatism: effects of prostatic symptoms on spouses’ quality of life, daily routines, and family relationships. *Fam Pract.* 2001;18:610-613.
7. AUA Practice Guidelines Committee. AUA guideline on management of benign prostatic hyperplasia (2003). Chapter 1: diagnosis and treatment recommendations. *J Urol.* 2003;170(pt 1):530-547.